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# Attitudes towards sex offenders: a review of therapists' attitudes and their impact on therapeutic alliance, and a qualitative study of support workers' attitudes towards sex offenders with intellectual disabilities.

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**Doctorate in Clinical Psychology**

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# DClinPsychol Declaration of Own Work

**Name:** Olga Czosnyka

**Title of Work:** Attitudes towards sex offenders: a review of therapists' attitudes and their impact on therapeutic alliance, and a qualitative study of support workers' attitudes towards sex offenders with intellectual disabilities.

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**Signature** **Date** 31.07.18

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**Contents Page**

**Research Portfolio Abstract**

**Background and aims**: Little is known about how therapists' attitudes impact on therapeutic alliance in their clinical work with sex offenders, and what attitudes support workers, who work with sex offenders with intellectual disabilities, hold towards their clients. Research suggests that therapeutic alliance can strongly influence the effectiveness of therapy, and that positive attitudes towards sex offenders are important for their rehabilitation. Understanding how therapists' attitudes influence the therapeutic alliance may help in developing more effective psychological therapies, and research on support workers' attitudes may provide better understanding of their experience of working with sex offenders with intellectual disabilities.

The objective of the review was to explore what attitudes therapists working with adult male sex offenders hold towards their patients, and how their attitudes impact on therapeutic alliance. The aim of the empirical study was to explore the experiences and attitudes of support workers who work with sex offenders with intellectual disabilities.

**Method**: a systematic review was conducted to explore the objective of the review. An electronic and hand literature search was conducted using PsycINFO, Medline, EMBASE and CINAHL databases in accordance with outlined inclusion and exclusion criteria. Ten studies met the inclusion criteria for this review: 6 qualitative and 4 quantitative papers. The empirical project was conducted using qualitative methodology. The sample of participants consisted of four female and seven male participants. Data was collected through semi-structured interviews and analysed in accordance with Braun and Clarke's (2006) six stages of thematic analysis.

**Results**: the results of the review were common themes identified across the literature: therapists' attitudes becoming more positive through the experience of working with sex offenders, and difficulties with establishing therapeutic alliance with sex offenders. The results of the empirical study were: workers were found to be motivated to enter the profession by their values and beliefs, such as that everyone deserves help. Participants reported having positive attitudes towards sex offenders, perceiving them as human beings, as well as some negative attitudes like mistrust. Some negative impact of the

occupation was described by respondents, although they used coping strategies to manage some of these.

**Conclusion:** There were concerns over the methodological qualities of some of the reviewed papers. The objective of the review wasn't fully addressed by the assessed studies. Furthermore, targeted research is needed to examine the impact of therapists' attitudes on their clinical practice with this population. Attitudes towards sex offenders with intellectual disabilities were found to be quite diverse. Some gender-related differences were outlined in relation to the perception of safety and courtesy stigma.

**Research Portfolio Lay Summary**

The first paper looked at what therapists, who work with sex offenders, think about their patients. The relationship that therapists have with their patients (called therapeutic alliance) is important for the results of therapy. Therapists need to be warm, supportive and understanding towards their patients. Research shows that most people see sex offenders negatively. It may be more difficult to form therapeutic alliance with patients, who are sex offenders. The way that therapists see sex offenders may affect therapeutic alliance with them and make therapy less or more effective. Some research was carried out to look at how therapists view their patients, who are sex offenders. Research shows that most therapists change their views about sex offenders, because when they start working with them, they get to know them better. They can also see that sex offenders are people with problems, and that makes being understanding easier. Even though therapist's' views about sex offenders become more positive, they also have some negative views about them, for example therapists do not feel that they can trust sex offenders. It seems that there is not enough research about how therapists' views affect therapeutic alliance with sex offenders. More research is needed to find out about that.

The second paper is about support workers, who work with sex offenders with learning disabilities. Research shows that most people, who work with sex offenders (like police officers, prison staff and nurses) have better views on them than people, who don't work with them. There is very little research on what support workers think about sex offenders, and even less about what they think about sex offenders with learning disabilities. That's why we did our own research to find out what support workers think about sex offenders with learning disabilities. We also wanted to find out what is it like for support workers to work with them. We spoke to eleven support workers, and they told us about their experience. Support workers said that they wanted to work with sex offenders, because they believe that everyone deserves help. Some of the support workers said that they always had positive views about sex offenders, some said that their views became more positive since they started working with sex offenders. Some support workers spoke about difficulties in working with sex offenders with learning disabilities. Several of the support

workers said that the way that most people see sex offenders, makes it harder for them to rehabilitate and to stop offending. More research is needed to see if other support workers have similar experiences.

**Journal article 1: Systematic Review**

# What attitudes do therapists working with adult male sex offenders hold towards this client group, and how do their attitudes impact on therapeutic alliance? A Mixed Methods Systematic Review

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**Abstract**

Research suggests that therapeutic alliance can strongly influence the effectiveness of therapy. However, relatively little is known about how therapists' attitudes impact on therapeutic alliance with sex offenders. Understanding how therapists' attitudes may influence the therapeutic alliance may help in developing more effective psychological therapies. The objective of this review was to explore what attitudes therapists working with adult male sex offenders hold towards their clients, and how their attitudes impact on therapeutic alliance. Ten studies met the inclusion criteria for this review: 6 qualitative and 4 quantitative papers. Common themes identified across the literature were: therapists' attitudes becoming more positive through the experience of working with sex offenders, and difficulties with establishing therapeutic alliance with sex offenders. There were concerns over the methodological qualities of some of the reviewed papers. Further, targeted research is needed to examine the impact of therapists' attitudes on their clinical practice with this population.

## Introduction

The importance of therapeutic alliance is widely acknowledged in the research literature, with many authors agreeing that the quality of therapeutic relationship is, in fact, more important for the outcome of therapy than the nature of the clinical intervention itself (Ardito & Erabellino, 2011; Arnow et al., 2013, Blow et al., 2007; Duncan et al., 2004; Ward & Brown, 2004), and accountable for approximately 25% of variance in effectiveness of treatment (Horvath et al., 2011, Martin et al., 2000, Morgan et al, 1982). Positive therapeutic alliance is also believed to be associated with lower attrition rates from therapy (Beckham, 1992; Piper et al., 1999; Samstag et al., 1998; Tyron & Kane, 1990). According to Norcross and Lambert (2014), patients undergoing a clinical intervention from a therapist who is empathetic and person-centred, are likely to receive greater benefit than those whose therapist does not possess those attributes.

Although there is no single definition of therapeutic alliance that is accepted universally (Del Re et al, 2012), Bordin's (1979) three-aspect concept of therapeutic alliance provides some consensus in the literature, with the key elements being identified as: (i) the agreement on therapeutic goals and (ii) tasks, and (iii) development of a personal bond between patient and therapist (Hatcher & Barends, 2006; Horvath & Bedi, 2002). Bordin's (1979) definition is often quoted in literature on therapeutic alliance and considered to be a "pan-theoretical concept" that can be applied to any given therapeutic approach (Horvath & Luborsky, 1993). While some authors argue that therapeutic relationship, by its nature, is more than just a combination of individual elements, and attempts at analysing it may be "dividing the undividable" (Stiles, 1998), factors like empathy, positive regard and congruence (Rogers, 1951) are commonly considered to be necessary components in forming a therapeutic relationship.

### *Therapeutic Alliance in Sex Offender Treatment*

Much of the literature on therapeutic alliance has involved individuals with a variety of mental health difficulties such as mood disorders or psychotic illnesses (Horvath &

Luborsky, 1993), yet therapists may also provide psychological treatment where empathy, positive regard and congruence are more difficult to establish with clients. In comparison to findings from the studies looking at therapeutic alliance in general practice, research focusing on the therapeutic relationship in clinical practice with sex offenders seems to provide strikingly similar results. Therapists' person-centred approach: empathy, genuineness, respect, warmth and accepting and caring behaviour appear to be crucial for the forming of positive therapeutic relationship, while lack of the above, confrontational approach, hostility and negative attitude, and therapists' rigidity and arrogance, were listed as factors impeding development of therapeutic alliance (Beech, & Hamilton-Giachritsis, 2005, Binder & Strupp, 1997; Marshall et al., 2003, Miller et al., 2003; Norcross and Lambert, 2014; Watson & Geller, 2005).

Yet, it could be argued that establishing collaborative relationship with sex offenders can be more difficult than with other groups. Shingler and Mann (2006) described the population of sex offenders as challenging patients to engage. In addition to a complex presentation, sex offenders often do not attend therapy on voluntary basis, which makes establishing collaboration particularly difficult. Delivering therapeutic interventions in a restrictive environment such as prison or high-security facilities provides another obstacle. Yet, therapists' own characteristics can impact on the therapeutic alliance just as much. Lack of confidence and experience in working with high-risk offending behaviour and negative perception of sex offenders were identified by the authors as common factors impacting on the effectiveness of therapeutic interventions with sex offenders (Shingler & Mann, 2006).

### *Definition and measurements of attitudes*

Historical conceptualisations of attitude have been relatively broad and inclusive; for example, in a sense of "predisposing the individual's response to all encountered objects and experiences" (Krosnick et al, 2005). However, in contemporary literature the definition of attitude tends to be focused on one object, and the role of attitudes in influencing the person's behaviour towards that object (Krosnick et al, 2005; Allport, 1935). Eagly and Chaiken's (1993) definition of an attitude as "a psychological tendency

that is expressed by evaluating a particular entity with some degree of favour or disfavour" (p. 1) is an example of such an approach.

Although the concept of attitude appears to be clearly defined, it is acknowledged within literature that the measurement of attitudes can present challenges, and that there appears to be no consensus in contemporary literature as to the best assessment approach (Krosnick et al, 2005). The attitude itself is a latent evaluation of an object, but resulting in measurable cognitive, affective and behavioural responses towards its object (Eagly and Chaiken, 2007). Therefore, some authors argue that what is being measured when assessing attitudes is not the attitudes themselves, but their manifestations, leading to errors and imperfections in research (Krosnick et al, 2005). An example of such bias was pointed out by Harper et al. (2017) in their review of literature on attitudes towards sex offenders. According to the authors, many studies lack an in-depth approach and a clear definition of what is being measured, often assessing what could be described by a narrow concept of perceptions or knowledge-based attributions, rather than attitudes. It was also noted that research conducted on the responses towards sex crime was frequently labelled as an exploration of attitudes towards sex offenders, while in fact measuring a related, but essentially different, concept.

### *The importance of attitudes*

Public and professionals' attitudes towards sex offenders have been found to have significant implications for the manner in which this group is treated within criminal justice system, such as decision making when it comes to release back into the community, as well as their rehabilitation (Harper et al, 2017). Yet, public attitudes towards sex offenders are known to be predominantly negative, and upon their re-entering of the society, sex offenders find themselves surrounded by hostility, often experiencing hindrance from members of the public, and professionals involved in their care, alike (Harper et al, 2017; Willis et al 2010).

Based on what we know of therapeutic alliance, to be able to effectively treat sex offenders, therapists must be able to maintain unconditional positive regard towards their patients in order for optimal treatment effectiveness. However, as Marshall et al. (2003)

pointed out, it appears that the notion of importance of collaboration in working with sex offenders was not originally given much attention.

According to Marshall et al. (2003), early treatment programmes for sex offenders were heavily grounded in behaviourism, and the role of the therapist was not perceived as particularly influential. More recently, that began to change, and the importance of therapeutic relationship in achieving behavioural and cognitive changes, when working with sex offenders, gained recognition (Marshall et al., 2003). The outcome of therapeutic intervention, even the one based on a manualised protocol, was shown to be partly explained by the personal characteristics and behaviour displayed by the therapist (Marshall, 2005). Patients of therapists, who displayed warmth and empathy, had a greater chance of benefiting from the intervention, and as a result, addressing their offending behaviour (Marshall, 2005, Marshall et al., 2003, Serran et al., 2003).

Considering that their clients are individuals who have committed sexual offences, feeling warm and empathetic towards that population may not be an easy task. Greenberg (2010) postulates that not only the techniques used in the therapy room, but also the therapist's attitude affects a client's wellbeing and engagement. While it is recognised that negative attitudes held by therapists who work with sex offenders are likely to impact on therapeutic alliance, and potentially impede the outcome of the intervention (Marshall, 2005), it appears that very little is known about how attitudes of therapists affect their clinical practice, as well as their own wellbeing (Harper, 2017).

The aim of this review is to explore existing research on attitudes held by therapists working with male sex offenders, and to draw conclusions and implications that therapists' attitudes have in clinical work with that population. The decision to limit the sample of reviewed papers to the therapists' working with male sex offenders only was dictated by the fact that the vast majority of sex offenders are believed to be male (Cortoni et al.,2010) and the objective to achieve the most homogeneous sample of research possible. Additionally, research suggests that attitudes of professionals towards female sex offenders may be more favourable than towards male perpetrators, and that sex offences committed by females are seen as having a lesser impact on the victim, than male-perpetrated sexual abuse (Clements et al., 2014; Mellor & Deering, 2010).

For the purpose of this review, Eagly and Chaiken's (1993) definition of an attitude as "a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour" (p. 1) was used.

**Objective**: What attitudes do therapists working with adult male sex offenders hold towards this client group, and how do their attitudes impact on therapeutic alliance?

## Method

### *Inclusion Criteria*

1. Studies published in English.
2. Studies assessing attitudes of mental health therapists (e.g., psychologists, counsellors) towards adult male sex offenders.
3. Studies that utilised either qualitative, quantitative or mixed methods analysis of primary-source data.
4. Study participants that had experience of working directly with male adult patients who were sex offenders.
5. All research participants were therapists with experience of working with adult male sex offenders, or studies where the overall sample was not exclusively therapists, they formed a distinct comparison group (e.g., comparison of attitudes of therapists and general public).
6. Studies measuring and describing therapists' attitudes towards male adult sex offenders or studies where exploration of attitudes was not a primary objective, yet which directly measured attitudes, were also included.

### *Exclusion Criterion*

1. Studies focusing on topics related to attitudes towards sex offending in general (e.g., attitudes towards the Sex Offender Register), but not on direct attitudes towards sex offenders.

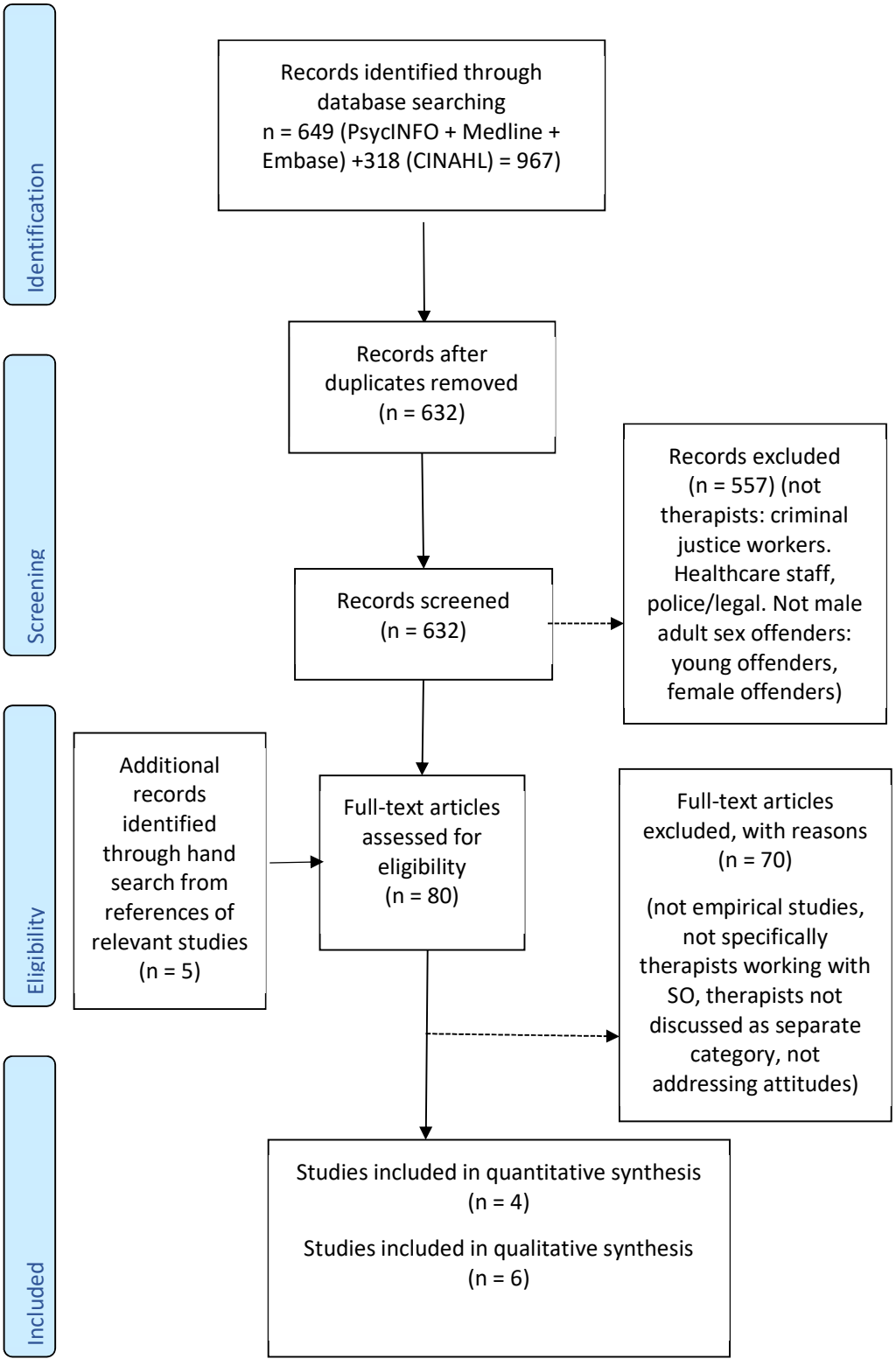


*Figure 1: Flowchart of the selection of studies*

***Search Strategy and Review Procedure***

The search was performed in November 2017, following Prisma guidelines (Moher et al, 2009). The following online social science and medical databases were searched (with period covered): PsycINFO (1806-2017), Medline (1946-2017), EMBASE (1980-2017) and CINAHL (1937-2017). The stated year limit was the maximum period covered available through each database and both empirical qualitative and quantitative studies and theses were included. The lack of specificity on the methodology of included papers, as well as no publication year limit being applied to the search results can be justified by the small number of papers published on the subject of this review.

Key terms used were: "sex* offen*", rapist*, paedophile* or pedophile*, personnel or therapist* or counsellor* or counselor* or "social worker*" or professional*, attitude* or perception* or belief*. Terms were exploded and used singularly or in conjunction as appropriate to each database. The use of wide range of key terms can be justified by the fact that using specific terms, such as therapeutic alliance* would make the search too restrictive for the purpose of this review.

After removing duplicates, the initial search resulted in 632 papers potentially relevant for this review, which were then screened based on titles and abstracts. 557 studies were excluded, and the remaining 75 papers were identified as eligible for full text review and their bibliography was examined for any relevant papers not already identified. During the hand search stage, 5 more papers were obtained and included. The inclusion and exclusion criteria were applied to 80 full text studies resulting in exclusion of further 70 papers. The remaining 10 studies (including 1 study obtained through hand search) were eligible for the analysis and included in this review.

A 10% sample of the 80 papers selected at the “eligibility” stage of search was checked by an independent reviewer against the inclusion and exclusion criteria. The results of that check were consistent with the previously conducted selection of eligible studies.

***Quality assessment tools***

The Clinical Appraisal Skills Programme (CASP) Qualitative Research Checklist (Appendix 2) and Case Control Study Checklists (Appendix 3) (http://www.casp-uk.net/casp-tools-checklists) were chosen to assess the methodological quality and the risk of bias of selected papers. Due to the mixture of qualitative and quantitative studies reviewed in this paper, CASP checklists appeared to be the most appropriate, as they offer a variety of tools for assessment of both qualitative and quantitative studies and are similar in structure, offering transparency in comparing the papers. The choice of tools was made in accordance with CASP guidelines. Risk of bias was assessed by the lead author and an independent reviewer on the whole sample of assessed studies. There were no major discrepancies on the ratings and a consensus was established.

## Results

### *Descriptive details of the included studies.*

Table 1: Descriptive details of the included qualitative studies.

| Author and location | Methodology | Sample characteristics | Summary points and key findings | Limitations |
|---|---|---|---|---|
| **Collins, S. & Nee, C.**<br>2010<br>UK | Qualitative: semi-structured interviews<br><br>Analysis: Foucauldian discourse analysis | Therapists working with SO (n=4) | Objective: how therapists view the change process in their clients. Exploration of therapists' role as mediators of change. Positive and negative aspects of working with SO.<br><br>Results: sex offender identity – SO perceived by therapists as different to the rest of the society. Different therapeutic approaches applied depending on the type of offence. Presence of bias – SO perceived as more manipulative and deviant than other offenders, and unable to change their sexual interests. | Small sample recruited within one service.<br>Participants were recruited amongst sex offender treatment programme facilitators – little training and experience required to perform the role. |
| **Elias, H. & Haj-Yahia, M.**<br>2017<br>Israel | Qualitative: semi-structured interviews<br><br>Analysis: grounded theory | Social workers (n=19) delivering therapy to SO | Objective: examination of therapists' attitudes towards SO and their perceptions around encounter with them. Focus on changes in attitudes and gender differences in attitudes towards SO. | Unclear whether participants were trained therapists or other staff involved in delivery of a manualised treatment programme. |

| Author and location | Methodology | Sample characteristics | Summary points and key findings | Limitations |
|---|---|---|---|---|
| | | | Results: therapists attributed motives for offending behaviour as stemming from developmental difficulties or mental disorder.<br>Perception of SO as complex, manipulative and damaged.<br>Changes in perception over time – from negative attitudes to more empathetic approach.<br>Gender differences – male therapists saw inability to control sexual impulses as the main motive for committing sex offences, while female therapists identified broad range of factors leading to offending (developmental disorders etc.). | |
| **Friedrich, M. & Leiper, R.**<br>2006<br>UK | Qualitative: semi-structured interviews<br>Analysis: interpretative phenomenological analysis | Therapists working with incestuous offenders (n=9) | Objective: exploration of therapists' reactions to working with sex offenders.<br><br>Results: negative (anger, criticism, hostility and disgust), and complex and ambivalent (shame for having negative attitudes towards SO, guilt, feeling surprised for having positive feelings towards SO) reactions.<br>Expectation of being deceived and manipulated by SO during therapeutic work.<br>Empathy towards SO. Empathetic attitude easier to maintain after therapists got to know the SO better, but with some therapists struggling to feel empathetic altogether.<br>Humanising and objectifying SO – tension between two contradictory attitudes. | Sample consisted of therapists working with incestuous sex abusers only. |

| Author and location | Methodology | Sample characteristics | Summary points and key findings | Limitations |
|---|---|---|---|---|
| **Moore, S.**<br>2016<br>USA | Qualitative: interviews<br>Analysis: consensual qualitative research approach | Therapists working with SO (n=7) | Objective: exploration of countertransference issues appearing in clinical work with male SO.<br><br>Results: "positive" or "supportive", negative (resentment, anger, frustration and disgust), and sexual (attraction towards the client and arousal caused by topic of conversation) feelings encountered by therapists. | Self-selected sample (through email response),<br>Anticipated minimal sample of 8 not met.<br>Rigorous inclusion/exclusion criteria applied.<br>Not peer-reviewed: thesis. |
| **Polson, M & McCullom, E.**<br>1995<br>USA | Qualitative: structured interviews<br>Analysis: case study with content analysis, | Female therapists working with SO (n=4)<br><br>Male sex offenders (n=3) (not included in review) | Objective: how therapists maintain genuine caring attitudes towards SO, management of negative feelings in therapeutic work, exploration of benefits of working with SO.<br><br>Results: therapists reported to use *cognitive frames* to enhance a positive view of SO – viewing them as victims and people with problems, who are still loved by their families and deserve treatment.<br>Management of negative feelings by addressing dysfunctional client behaviours and beliefs, controlling personal reactivity through coping strategies, and accepting limitations of therapy, and risk of reoffending. | Very small sample limited to female therapists only.<br>All participants and one of researchers worked in the same team.<br>Research hypothesis formed around preconception that all therapists working with SO must be experiencing negative feelings towards them. |
| **Scheela, R**<br>2001<br>USA | Qualitative: unstructured face to face interviews<br>Analysis: constant comparative analysis | Therapists working with SO (n=17) | Objective: exploration of experiences and perceptions of therapists working with SO.<br><br>Results: Attitudes towards SO prior to working with them reported by therapists as apprehensive: concerns over impact on personal and professional life, over experiencing solely negative attitudes, and great sense | Unclear what proportion of sample consisted of therapists working with adult male sex offenders (described to be a majority).<br>All participants worked in the same service. |

| Author and location | Methodology | Sample characteristics | Summary points and key findings | Limitations |
|---|---|---|---|---|
| | | | of perceived responsibility for effective treatment and reoffending prevention.<br>After gaining experience of working with SO: change in attitudes: perception of SO not as monsters but human beings, seeing their offence as an act separate from the person. More realistic expectations of therapy outcomes and reported enjoyment of working with sex offenders (viewed as "a challenge and privilege"), but also feeling desensitised.<br>Offender treatment seen as effective, SO perceived as able to change. Therapists placed their attitudes in opposition to generally negative public views of SO. | Researcher was part of the team and involved in designing locally delivered offender treatment programme.<br>Very little information provided about data analysis. |

Table 2: Descriptive details of the included quantitative studies.

| Author and location | Methodology | Sample characteristics | Summary points and key findings | Limitations |
|---|---|---|---|---|
| **Barabas, D.** 2007 USA | Quantitative: survey re: attitudes (Likert scale)<br><br>Analysis: descriptive analysis (percentages) | Therapists working with sex offenders. (n = 16) | Objective: investigation of therapists' attitudes towards SO, levels of burnout and empathy towards SO. Investigation of the correlation between the three aspects.<br><br>Results: majority of participants supported imprisonment, segregation and public notice of SO, at the same time agreeing that SO can be rehabilitated. Therapists reporting their work as rewarding and majority did not feel anger towards SO. Lack of trust between therapist and SO perceived by majority. | Small sample recruited within same organisation.<br>No statistical analysis of the results.<br>Not peer-reviewed: thesis. |
| **Dooley, R.** 2009 USA | Quantitative: responses to scenarios<br><br>Analysis: Kruskal-Walles and Mann Whitney U | 75 mental health professionals, 124 public sample (adults). (n=75) | Objective: are perceptions of therapists working directly with SO affected by level of treatment received by SO (no treatment, moderate and extensive treatment)? Compared to public sample.<br><br>Results: SO who received the longest treatment were perceived by therapists as more likely to be rehabilitated.<br>Therapists' attitudes towards living near a SO, providing SO with the same opportunities as other citizens, and increasing spending on rehabilitation of SO were not affected by the level of treatment received by SO.<br>Compared to public sample, therapists had significantly more positive attitudes towards endorsing treatment and living near SO in moderate treatment group. | |

| Author and location | Methodology | Sample characteristics | Summary points and key findings | Limitations |
|---|---|---|---|---|
| **Farrenkopf, T.**<br>1992<br>USA | Quantitative: structured questionnaire survey<br><br>Analysis: not stated | Therapists working with sex offenders (n=24) | Objective: exploration of impact of working with SO.<br><br>Results: four stages of "attitude adjustment" towards SO:<br>1. Shock – fear and feeling vulnerable,<br>2. Mission – desire to help the client and empathetic attitude,<br>3. Anger – therapeutic alliance becomes disrupted by occurrences of SO denial and reoffending, resulting in confrontive attitude and intolerance by therapist,<br>4. Either erosion (burnout) or adaptation (detached attitude and lowering of expectations). | Very little information about used methodology.<br>No information about survey questionnaire used and questions asked. |
| **Veach, T.**<br>1999<br>USA | Quantitative: questionnaire (Likert scale)<br><br>Analysis: one way ANOVA | Therapists working with sex offenders (n=40)<br>Sex offenders (not included in analysis) (n=34)<br>Comparison group (students) (n=57) | Objective: comparison of attitudes towards child sex abuse between therapists, SO and public.<br><br>Results: significant differences between attitudes of therapists and control group towards:<br>• punishment of SO, with therapists being less supportive of severe punishment,<br>• sexual contact with children, with therapists having more rigid attitude to when physical contact is appropriate than general public. | Focus on attitudes towards child sex offenders only. |

***Methodological characteristics.***

***Table 3: Quality appraisal of qualitative studies.***

| *Author* | *1* | *2* | *3* | *4* | *5* | *6* | *7* | *8* | *9* | *10* |
|---|---|---|---|---|---|---|---|---|---|---|
| **Collins & Nee, 2010** | Yes | Yes | Yes | Can't tell | Yes | No | Yes | Yes | Yes | Very valuable<br>Construct of sex offender identity, presence of bias in attitudes towards SO. |
| **Elias & Haj-Yahia, 2017** | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Yes | Yes | Very valuable<br>Analysis of positive and negative attitudes towards SO, change in attitudes with time and gender differences in perception of causes of offending behaviour. |
| **Friedrich & Leiper, 2006** | Yes | Yes | Yes | Yes | Yes | No | No | Yes | Yes | Very valuable – exploration of positive and negative attitudes towards SO. |
| **Moore, 2016** | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Very valuable<br>Description of the range of feelings towards SO. |
| **Polson & McCullom, 1995** | Yes | Yes | Can't tell | Yes | Yes | No | No | Yes | Yes | Very valuable<br>Insight into management of negative feelings towards SO |
| **Scheela, 2001** | Yes | Yes | Yes | Can't tell | Yes | No | No | Yes | Yes | Very valuable<br>More positive attitudes through becoming familiar with population of SO. |

Note: (1) *Was there a clear statement of the aims of the research?* (2) *Is a qualitative methodology appropriate?* (3) *Was the research design appropriate to address the aims of the research?* (4) *Was the recruitment strategy appropriate to the aims of the research?* (5) *Was the data collected in a way that addressed the research issue?* (6). *Has the relationship between researcher and participants been adequately considered?* (7) *Have ethical issues been taken into consideration?* (8) Was *the data analysis sufficiently rigorous?* (9) *Is there a clear statement of findings?* (10) *How valuable is the research?*

***Table 4: Quality appraisal of quantitative studies.***

| *Author* | *1* | *2* | *3* | *4* | *5* | *6a* | *6b* | *7* | *8* | *9* | *10* | *11* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Barabas, 2007** | Yes | Yes | Can't tell (descriptive analysis only) | n/a | Can't tell | None mentioned | / | See table 2 | Descriptive analysis only, (statistical analysis was possible but not conducted). Additionally, it is likely the study would have been underpowered due to sample size. | No Due to results being descriptive, there is a large potential for bias. | No | Yes |
| **Dooley, 2009** | Yes | Yes | can't tell (the study appears to be considerably underpowered and therefore results are questionable) $\beta = 0.49$ | Yes | Can't tell | Geographical location | Yes | See table 2 | Results described in great detail, but effect sizes aren't always present. For results described as significant, it is not clear how big the differences between the groups are. | No, because the study appears to be underpowered | Yes for therapists No for public sample | Yes |
| **Farrenkopf, 1992** | Yes | Yes | Can't tell (Descriptive analysis only) | n/a | Can't tell | None mentioned | / | See table 2 | Only descriptive analysis No statistical analysis conducted No information on the measure used. | No, not enough information provided about the methodology of the study and the tool used. | Can' tell | No |
| **Veach, 1999** | Yes | Yes | Yes | No | Can't tell | None mentioned | / | See table 2 | Large effect size Study is powered | Yes, limited by recruitment strategy | Can't tell | Yes |

Note: (1) *Did the study address a clearly focused issue*? (2) *Did the authors use an appropriate method to answer their question?* (3) *Were the cases recruited in an acceptable way?* (4) *Were the controls selected in an acceptable way?* (5) *Was the exposure accurately measured to minimise bias*. (6a) *What confounding factors have the authors accounted for?* (6b) *Have the authors taken account of the potential confounding factors in the design and/or in their analysis?* (7) *What are the results of this study?* (8) *How precise are the results? How precise is the estimate of risk?* (9) *Do you believe the results?* (10) *Can the results be applied to the local population* (11) *Do the results of this study fit with other available evidence?*

***Key findings - Qualitative studies***

Out of ten reviewed studies, six used qualitative methodology (Collins & Nee, 2010; Friedrich & Leiper, 2006; Elias & Haj-Yahia, 2017; Moore, 2016; Polson & McCullom, 1995; Scheela, 2016). The sample across the studies consisted of 60 participants, with 32 participants working with the general population of male sex offenders (Collins & Nee, 2010; Elias & Haj-Yahia, 2017; Moore, 2016; Polson & McCullom, 1995; Scheela, 2016), and 9 therapists working solely with sex offenders who had committed offences relating to incest (Friedrich & Leiper, 2006). Sample sizes varied from 4 to 19, and studies were conducted across the USA (3), UK (2) and Israel (1). Except for two papers, which were theses (Barabas, 2007; Moore, 2016) all studies were published and peer-reviewed.

Qualitative studies suffered from some methodological weaknesses: only two papers addressed ethical considerations of their research (Collins & Nee, 2010; Elias & Haj-Yahia, 2017) and only one addressed the influence of the researcher on the process of obtaining and interpreting of data (Elias & Haj-Yahia, 2017). The representativeness of the sample that caused the reason for concern. Elias and Haj-Yahia (2017) description of their sample was somewhat confusing when it came to the nature of the role of their participants – it was not clear whether they were trained therapists, or staff who was involved in delivering a manualised intervention. The sample of participants in Collins & Nee's (2010) study consisted of four sex offender treatment programme facilitators, who had limited therapeutic experience. In three studies (Collins & Nee, 2010; Polson & McCullom, 1995; Scheela, 2016) participants were recruited within one service, and within these, in two (Polson & McCullom, 1995; Scheela, 2016) the researchers themselves also worked within those teams. That issue was recognised and addressed by some authors (Polson & McCullom, 1995).

Thematic synthesis was conducted in accordance with guidelines by Harden and Thomas (2008). This method was chosen as the most appropriate to translate common concepts between studies focusing on varying research questions and methodological approaches. In this three stages approach, the content of the results section of each of the reviewed studies was approached as research data, coded and grouped into descriptive themes.

Analytical themes were then developed to synthesise research findings and answer the research question of this review.

Table 3: Themes emerging from thematic synthesis and their presence in assessed qualitative papers.

| Author | Theme 1: Therapists' Attitudes Towards Sex Offenders. | | Theme 2: Therapeutic Alliance in Clinical Practice with Sex Offenders | |
|---|---|---|---|---|
| | Subtheme 1: Struggling with Negative Attitudes Towards Sex Offenders. | Subtheme 2: Positive Change in Perception of Sex Offenders | Subtheme 1: Questioning Own Abilities | Subtheme 2: Strategies to Manage Difficulties with Therapeutic Alliance |
| **Collins & Nee, 2010** | **X** | | **X** | **X** |
| **Elias & Haj-Yahia, 2017** | **X** | **X** | **X** | **X** |
| **Friedrich & Leiper, 2006** | **X** | **X** | **X** | **X** |
| **Moore, 2016** | **X** | **X** | **X** | **X** |
| **Polson & McCullom, 1995** | **X** | **X** | **X** | **X** |
| **Scheela, 2001** | **X** | **X** | **X** | **X** |

**Theme 1: Therapists' Attitudes Towards Sex Offenders.**

An analysis or research findings of six reviewed papers revealed that therapists working with sex offenders experienced a mixture of negative (such as anger and disgust) and positive (seeing sex offender as human being) attitudes towards their patients in their day-to-day practice. While most researchers reported therapist' attitudes become more

positive over time, it appears that negative attitudes were present, even in experienced practitioners.

***Subtheme 1: Struggling with Negative Attitudes Towards Sex Offenders.***

An acknowledgement of negative attitudes towards sex offenders, held by therapists, is present in all six included papers, whether in the form of anger (Friedrich & Leiper, 2006; Moore, 2016; Polson & McCullom, 1995), or disgust and repulsion (Collins & Nee, 2010; Friedrich & Leiper, 2006; Elias & Haj-Yahia, 2017; Moore, 2016; Polson & McCullom, 1995):

> *Yes, I have felt real disgust, like when a man talks really specifically of what he has done, when he was in his daughter's bedroom and how he lifted the covers up, when he was describing exactly what he was doing. I guess I feel disgust when it feels like they are re-living it and they are not just telling it for the group to process it. I feel they are really enjoying telling it and that is when I feel really disgusted* (Polson & McCullom, 1995)

The results of all qualitative studies included in this review also mention that the therapists perceived sex offenders as manipulative and deceitful. Some therapists reported feeling "condemning" and "judgemental" towards sex offenders, especially when faced with their denial and resistance, and feeling guilty for displaying "surface acceptance" during therapeutic work (Friedrich & Leiper, 2006).

***Subtheme 2: Positive Change in Perception of Sex Offenders***

Five out of six studies indicated that therapists working with sex offenders found that their attitudes towards sex offenders became more positive after gaining experience of working with that population (Elias & Haj-Yahia, 2017; Friedrich & Leiper, 2006; Moore, 2016; Polson & McCullom, 1995; Scheela, 2016):

> *I think that today my perceptions of them are not as harsh. That is, today I am better able to empathize with them. I'm far from the attitudes that the public has toward sex offenders* (Elias & Haj-Yahia, 2017).

*Human being and separating offence from the person*

While, initially, therapists' attitudes were described as apprehensive or punitive, over time they evolved into perceiving sex offenders as "human beings" (Friedrich & Leiper, 2006; Polson & McCullom, 1995), more than "just sex offenders" (Friedrich & Leiper, 2006; Polson & McCullom, 1995; Scheela, 2001), and their offence as separate from the person (Polson & McCullom, 1995; Scheela, 2001):

> *They go through a lot of pain trying to dig out the reason why they have done this. I always tell the perpetrator that what he has done is a very awful thing, he might have ruined a child's life, or at least ruined their childhood, but it still doesn't mean that that person is not a decent human being* (Polson & McCullom, 1995).

It appears that therapists' perception of sex offenders as human beings and their offence as separate from the person in some cases occurred somehow naturally through the therapists' experience of working with that population. Interestingly, however, Friedrich & Leiper (2006) reported one of their research participants using specific strategies to "make the client into a human being" to be able to work with them, which could be interpreted as evidence of purposefully forming positive attitudes towards sex offenders:

> *One talked about the importance of making the client into a human being to be able to work with him. She mentioned strategies to help herself to see the client as a person, such as starting the first interview with questions indicating concern about the client and therefore finding out more about him as a person rather than concentrating immediately on the sexual offences (Friedrich & Leiper, 2006).*

A similar strategy was also conceptualised by Polson & McCullom (1995) as "cognitive frames":

> *The therapists used these (...) purposefully or strategically as cognitive frames to nurture a positive view of the perpetrators they treated. In looking for data to fit the cognitive frames, the therapists probed for and retained certain kinds of personal information that exposed the offenders as "vulnerable," "impaired," or "human."* (Polson & McCullom, 1995).

It was however reported by the authors as insufficient in overcoming negative attitudes towards sex offenders and difficulties in forming therapeutic alliance, and the therapists were reported to be using a range of different coping strategies in addition to these.

## Theme 2: Therapeutic Alliance in Clinical Practice with Sex Offenders

Findings from previous section suggest that while therapists' attitudes towards sex offenders shifted towards more positive ones as they became more familiar with the population that they are working with, that did not mean that negative attitudes were not present. Therapists were reported to experience a range of negative feelings when working with that population, and they appeared to be using a variety of strategies to help them overcome difficulties in forming therapeutic alliance with sex offenders.

### *Subtheme 1: Questioning Own Abilities*

All six reviewed papers reported therapists to be experiencing a degree of uncertainty in regard to their level of skills when working with sex offenders, or the quality of therapeutic alliance and effectiveness of delivered by them interventions.

*Being deceived*

Amongst the commonly identified barriers to therapeutic alliance, feeling manipulated and controlled was the most frequently mentioned (Collins & Nee, 2010; Elias & Haj-Yahia, 2017; Friedrich & Leiper, 2006; Polson & McCullom, 1995):

> *He'd been triumphing over therapy ...he was having us all on really* (Friedrich & Leiper, 2006).

The perception of sex offenders as manipulative appear to be happening on a different level of depth. Some therapists saw it as a deeply embedded personal characteristic of the offender (Elias & Haj-Yahia, 2017). Others we described to perceive the sex offenders' manipulativeness on a behavioural level, with sex offenders' deceit impacting on therapists' ability to empathise with their patients and effectively engage them in a therapeutic intervention (Collins & Nee; 2010; Elias & Haj-Yahia, 2017; Friedrich & Leiper, 2006; Polson & McCullom, 1995). Some respondents identified being manipulated by sex offenders as "the hardest thing" (Polson & McCullom, 1995), other felt "duped" by their patients or felt that sex offenders' motivation for therapeutic work

was related to secondary gains, rather than willingness to address their difficulties or work towards change (Collins & Nee, 2010; Friedrich & Leiper, 2006):

> *well he's not really here to get a greater understanding of why he did do it, or why or how he justified it that he'd done it. He's here because he wants his parole or he's here because he wants to get out or it's part of his lifer review* (Collins & Nee, 2010).

*Sex offenders' cognitive distortions*

Sex offenders' denial, lack of remorse, blaming the victim or minimising the impact of the offence also appeared to be impacting on therapists' ability to uphold positive attitudes towards their patients (Collins & Nee, 2010; Elias & Haj-Yahia, 2017; Friedrich & Leiper, 2006; Moore, 2016; Polson & McCullom, 1995). Polson and McCullom gave an example of sex offenders' cognitive distortions triggering an emotional response in therapists:

> *I hear them doing their denial. The awareness of it - 'I might have done it when I was drunk' or when they are blaming the victim. I feel my thermometer goes up when I hear that and I have to step back twice.* Polson & McCullom

Sex offenders' distorted thinking impacted not only on therapists' ability to empathise with their patients, but also on their outlook on the future prognosis. Three studies (Collins & Nee, 2010; Friedrich & Leiper, 2006; Polson & McCullom, 1995) reported their participants worrying about to what degree their patients really addressed their distorted thinking. Additionally, Collins and Nee (2010) pointed out that the compulsory treatment for sex offenders further impairs the chances for participants to really engage with therapy:

> *The objective of the intervention had been corrupted from a desire to rehabilitate sex offenders effectively to a system ''where it's a case of you do the course to get out, you don't do the course to change behaviour''* (Collins and Nee, 2010).

*Personal impact*

Many therapists appeared to be struggling under the pressure of working with a high-risk population:

> *It can be exasperating, it's scary. You don't know if they're going to re-molest. It's a real calculated risk. Half the time I feel like I'm playing policeman, doing all the contacts with probation and it's really hard to do that* (Polson & McCullom, 1995)

All authors reported that their participants felt somehow responsible for effectively rehabilitating sex offenders, and worried about the risk of reoffending in their patients.

Three studies (Collins & Nee, 2010; Polson & McCullom, 1995; Scheela, 2016) described further personal impact of working with sex offenders. Collins and Nee (2010) reported that some of their participants felt blamed by sex offenders for the therapy not being effective enough, and Scheela (2016) stated that therapists were worried about the risk of retaliation from sex offenders, who were unhappy with their treatment. There was also evidence of impact of working with sex offenders on personal lives of therapists, with feeling affected emotionally (Collins & Nee, 2010; Polson & McCullom, 1995) with becoming more hypervigilant, especially in relation to children (Collins & Nee, 2010; Scheela, 2016) mentioned by the authors:

> *All the therapists reported being more suspicious of others' intentions. One therapist said, "I get real nervous when I hear people say, well, they're so good with kids."* (Scheela, 2016).

***Subtheme 2: Strategies to Manage Difficulties with Therapeutic Alliance***

The review of six qualitative papers seems to suggest that therapeutic alliance in clinical practice with sex offenders, while at times occurring naturally, more often than not is perceived to require active work on the part of the therapist. When it comes to forming and maintaining therapeutic relationships with sex offenders, it appears that therapists implement a range of strategies to help them overcome difficulties in clinical work with sex offenders.

*Developing empathy through perceiving sex offenders as vulnerable*

Authors reported that research participants were aware of the importance of empathy and acceptance in therapy and made active efforts to establish therapeutic alliance with sex offenders by trying to empathise with their patients and understand their way of thinking (Friedrich & Leiper, 2006; Moore, 2016; Polson & McCullom, 1995). In terms of effective ways of developing therapeutic alliance, there appears to be a consensus in reviewed literature that seeing their patients as vulnerable helped therapists develop empathic and caring attitudes towards them. Seeing sex offenders as people who are damaged, lacking interpersonal skills, suffering from complex mental health difficulties, and learning about their personal history of abuse, appears to enable therapists to empathise with them and see them as human beings (Collins & Nee, 2010; Friedrich & Leiper, 2006; Elias & Haj-Yahia, 2017; Polson & McCullom, 1995; Scheela, 2016).

> *...what makes it easier sometimes is when an incest offender gets caught and then reveals for the first time his own childhood abuse. And of course that makes the whole empathic issue easier to manage* (Friedrich & Leiper, 2006).

*Sense of achievement*

Another strategy that appears to be implemented in establishing therapeutic alliance in work with sex offenders, is therapists' focus on the benefits of their work on reducing reoffending and keeping the public safe (Elias & Haj-Yahia, 2017; Moore, 2016; Scheela, 2001). That "social mission" was reported to help therapists' maintain their positive attitudes towards the population that they are working with:

> *I think I've been helpful. I think the world is a better place for the efforts given. I go to sleep proud, happy* (Scheela, 2001).

Therapists also seemed to derive work satisfaction and sense of achievement from seeing their patients change and address their offending behaviour (Collins & Nee, 2010; Moore, 2016; Scheela, 2001):

> *it goes from helping them to identify you know encouraging motivation and then facilitating change itself* (Collins & Nee, 2010).

*Supervision*

The benefits of supervision and peer support were also identified in reviewed literature (Collins & Nee, 2010; Polson & McCullom, 1995, Scheela, 2001) as an important factor contributing to the therapists' ability to cope with demands of their role:

> *The therapists also described the weekly staff meetings with the whole sexual abuse treatment team as having a very positive impact on their work. The multidisciplinary nature of the team enhanced everyone's learning, and the team members were seen as very supportive of each other. The supervision they received from the director of the program and the team members during staffings was viewed as constructive and helpful* (Scheela, 2001).

Collins and Nee (2010) also pointed out that while their sample of sex offender treatment programme facilitators had little training and experience in working with that population, thanks to the supervision they were able to address their difficulties in empathising with their patients and minimise the negative impact of working with sex offenders.

***Key findings - Quantitative Studies***

Four studies used quantitative methodology (Barabas, 2007; Dooley, 2009; Farrenkopf, 1992; Veach, 1999). The sample across the studies was 155 male and female therapists, working with male sex offenders, and 181 members of general public. The sample size of therapist participants within studies ranged from 16 to 75. All studies were conducted in the USA. Two studies were peer reviewed published papers (Veach, 1999; Farrenkopf, 1992) and two were doctoral theses (Barabas, 2007; Dooley, 2009).

Methodological weaknesses of reviewed papers cannot, unfortunately, be overlooked. Out of four analysed studies, only one of them appeared to be powered (Veach, 1999), while two papers provided no statistical analysis whatsoever other than descriptive summary of findings (Barabas, 2007; Farrenkopf, 1992). This strong potential for reporting bias, alongside some concerns around the recruitment strategy (Barabas, 2007; Veach, 1999), and insufficient information about used methodology (Farrenkopf, 1992) cast doubt at the validity of obtained results and generalisability of findings on wider population of therapists working with sex offenders.

In terms of key findings from the quantitative studies, a summary of such proved to be a challenging task. The aims of the studies were diverse, hence drawing coherent conclusions was difficult. While the focus of both Barabas (2007) and Farrenkopf (1992) was on the impact of working with sex offenders on therapists, their findings appear to be contradictory: the former author reported gradual decrease of faith in their work; the latter indicated that therapists' working with sex offenders believe that their patients can be rehabilitated and derive strong work satisfaction from their clinical practice. Barabas (2007) however also reported that the majority of his respondents felt that there was little trust between them and their patients, and lack of agreement on goals of therapy.

Two remaining studies, while both compared therapists' attitudes to those of general public (Doley, 2009; Veach,1999), essentially looked at fundamentally different issues: the level to which attitudes towards sex offenders are influenced by the degree of treatment they received (Doley, 2009) and the differences in perception of severity of punishment, attitudes to sexual contact with children and victim blame (Veach, 1999).

Additionally, summarising findings was further complicated by the use of different, non-standardised tools by researchers. Barabas's (2007) survey appeared to be somewhat scattered in terms of its aim, assessing therapists' attitudes to their work and their patients, as well as towards legal proceedings and sex offenders living in the community. The unvalidated tool designed to be used in Veach's study (1999) appears to be offering a possibility of measuring direct attitudes towards sex offenders (items like: "everyone deserves a second chance, including child molesters" and "child molesters are not necessarily bad people"). However, due to the design of the questionnaire, these findings were not made available for separate analysis, but incorporated into one of the predetermined factors, the "severity of punishment". Doley's (2009) tool assessed variability of attitudes depending on sex offender's level of treatment and willingness to take responsibility for his offence. Farrenkopf (1992) provided no information about the tool used in his research.

It therefore appears that no further conclusions can be made, aside for outline of key findings of each of the studies already provided in Descriptive characteristics (Table 2) included in this review.

## Discussion

The objective of this review was to analyse and assess the existing research on therapists' attitudes towards sex offenders, and to explore the relationship between attitudes and therapeutic alliance. It appears that while the reviewed literature provided answers about what attitudes therapists held towards their patients, far less is known about the potential impact of these on clinical practice.

Findings from qualitative studies revealed that while therapists' attitudes towards sex offenders tend to become more positive over time, therapists also held some negative attitudes towards their patients, such as anger and disgust, and finding sex offenders to be manipulative. Participants were found to be mindful of how impactful their attitudes were on the therapeutic work with sex offenders, and to make active effort to induce positive attitudes towards the population that they are working with and use a range of strategies to aid forming of therapeutic alliance. Quantitative findings suggested that therapists hold more positive attitudes towards sex offenders than the general public.

### *Synthetizing qualitative and quantitate findings*

When comparing qualitative and quantitative research, consideration should be made of the relative strengths and limitations of each of the approaches. While quantitative methodology offers generalisable conclusions, its scope is often focused on a very specific area, revealing what is happening, but not always offering an explanation for why it takes place. Qualitative research, on the other hand, allows for in-depth exploration of the experience, that can however be subjective only to a small sample of participants (Creswell, 2013).

In the context of this review, while quantitative findings provided information about certain aspects of therapists' attitudes towards sex offenders, qualitative research offered insight into a broader range of attitudes and the process of how these attitudes were created and shaped by the experience of working with sex offenders.

*Impact of experience of working with sex offenders on therapists' attitudes*

With the exception of one paper suggesting otherwise (Farrenkopf, 1992), and one paper which did not address the subject of change in attitudes (Collins & Nee, 2010), all reviewed studies, exploring therapists' experience in clinical practice appear to indicate that therapists held a mixture of positive and negative attitudes towards their patients, and found satisfaction in their work. The results of the qualitative studies included in this review (Elias & Haj-Yahia, 2017; Friedrich & Leiper, 2006; Moore, 2016; Polson & McCullom, 1995; Scheela, 2016) suggested that therapists' attitudes became more positive over time, and that their work-related experiences changed the way in which they perceived sex offenders. Quantitative studies comparing attitudes of therapists to general public (Dooley, 2009; Veach, 1999) showed that therapists saw sex offenders more favourably, and Barabas (2007) stated that his participants enjoyed working with sex offenders and believed that their patients can be rehabilitated.

Therefore, it can be concluded that the majority of qualitative and quantitative findings indicate that the experience of working with sex offenders does not lead to more negative attitudes to that population and is likely to result in more positive attitudes towards sex offenders.

*Difficulties with therapeutic alliance*

All qualitative studies and both quantitative papers, looking at attitudes in clinical practice (Barabas, 2007; Farrenkopf, 1992) highlighted difficulties encountered in establishing and maintaining therapeutic alliance. These included mistrusts and feeling deceived by their patients (Barabas, 2007; Collins & Nee, 2010; Elias & Haj-Yahia, 2017; Farrenkopf, 1992; Friedrich & Leiper, 2006; Polson & McCullom, 1995) and doubting the effectiveness of delivered therapy (Barabas, 2007; Collins & Nee, 2010; Farrenkopf, 1992; Friedrich & Leiper, 2006; Polson & McCullom, 1995).

It appears then that a second conclusion that can be made about the overall findings from research on therapists' attitudes towards sex offenders. Difficulties in establishing therapeutic alliance seem to be common amongst therapists working with sex offenders.

### *Summary*

It was difficult to synthetize the reviewed literature.

As previously discussed, there were some methodological weaknesses identified when it comes to qualitative studies. The main difficulty, however, for synthesizing the findings from qualitative research were different research aims of each of the papers, and differing methodologies (see Table 1). While that in itself was by no means a weakness in research designs, the findings from the studies were difficult to compare and draw conclusions from.

Synthesizing results of quantitative research provided similar challenges. In addition to methodological shortcomings, different aims of the studies: comparison of attitudes of therapists and general public (Dooley, 2009; Veach, 1999), and exploration of therapists' attitudes in their clinical practice with sex offenders (Barabas, 2007; Farrenkopf, 1992), and different, non-standardised measures used by the researchers, complicated matters further.

In summary, it was difficult to answer the research question of this review: what attitudes do therapists working with adult male sex offenders hold towards their clients and how do their attitudes impact on therapeutic alliance?

While qualitative research offered detailed insight into therapists' attitudes, and factors influencing their attitudes it provided limited information as to how therapists' attitudes influence their clinical practice. Quantitative research provided perspective on certain aspects of therapists' attitudes, as dictated by the design of such studies. It appears that both research designs provided some interesting and valuable findings, which, however, need to be interpreted with consideration of the outlined methodological flaws.

### *Implications for future research*

Considering that a significant proportion of papers in this review was quite dated, and the consensus in terms of research findings appears to be limited by methodological weaknesses of the reviewed studies, it seems that while the existing research provides

some findings on therapists' attitudes towards sex offenders, the area of how therapists' attitudes influence therapeutic relationship is significantly under explored.

When looking at the objective of this review, in an ideal world, the results from qualitative and quantitative research on therapists' attitudes towards sex offenders would provide clear, concise, current and complimentary findings on what are the therapists' attitudes and how do they impact on their clinical practice. That does not appear to be the case.

The existing qualitative research partly addressed the objective of this review but provided little information about how therapists' attitudes impact on their clinical practice. Keeping in mind the previously discussed issue of sample representativeness, it also appears that there is a shortage of studies looking at attitudes of fully trained therapists delivering therapy to sex offenders. Additionally, since a large proportion of available studies appears to be quite dated, there is a need for more up-to date research.

Since it was impossible to answer the question of this review based on existing qualitative research, it appears that qualitative studies, looking at the attitudes of therapists and the impact of their attitudes on therapeutic alliance with sex offenders are very much needed. Basic research conducted in the area would be the main recommendation, with a future extension to conducting studies in specific areas, such as group interventions versus 1:1 therapy, and therapy delivered in correctional setting or in the community.

Quantitative research aims at producing results that can be generalised to a wider population (Creswell, 2013). Due to some methodological weaknesses of the reviewed studies that result was not fully achieved. The existing studies, looking at attitudes of therapists, seem to be lacking a clear focus on the attitudes towards sex offenders, rather than issues (Krosnick et al, 2005; Harper et al., 2017) and they offered little insight into how therapists' attitudes impact on therapeutic alliance with their patients. That appears to be in agreement with a notion made by Harper (2017) about the lack of research looking directly at attitudes of therapists working with sex offenders and the influence of such on the therapeutic relationship with their patients. While there is evidence on the relationship between therapist's style and effectiveness of treatment (Marshall, 2003; Marshall, 2005, Marshall et al., 2003, Serran et al., 2003) little is known about how the therapists' attitudes

translate directly into displayed by them interpersonal qualities, and as a result impact on the outcome of the delivered treatment.

### *Implications for clinical practice*

The quality of therapeutic alliance was shown to have a greater impact on the outcome of therapeutic intervention than the choice of therapeutic modality (Ardito & Erabellino, 2011; Arnow et al., 2013, Blow et al., 2007; Duncan et al., 2004; Ward & Brown, 2004). Factors such as therapist's warmth and empathy are believed to be maximising the effectiveness of sex offenders treatment (Marshall, 2003; Marshall, 2005, Marshall et al., 2003, Serran et al., 2003). An understanding of an impact of therapists' attitudes on therapeutic alliance and the outcome of therapy, while currently an unexplored area, may provide information that could be beneficial for clinical practice of therapists, as well as for rehabilitation and reoffending reduction of sex offenders.

At the same time, sex offenders are a high-risk population and difficult patients to engage (Shingler & Mann, 2006). The findings from this review indicate that while the majority of therapists' work hard to maintain therapeutic alliance with sex offenders, they are also affected by the negative attitudes towards them. In addition to potentially negatively affecting the outcome of therapy (Marshall, 2003;) these attitudes appear to be impacting on the therapists' perception of their own ability to effectively rehabilitate sex offenders and prevent reoffending.

The findings from this review indicate that such experiences may be common in therapists working with this population. Therefore, it seems that all therapists working with sex offenders would benefit from support and recognition of the widely experienced issues, as well as appreciation for their effort to build and maintain positive attitudes towards sex offenders.

The impact of the experience of working with sex offenders on therapists' attitudes also appear to be an important finding for clinical practice. Alongside the strategies used by therapists to enhance positive attitudes, this knowledge could help practitioners who are

starting to work in this field to adjust their expectations of their clinical practice and minimalize the negative impact of working with sex offenders on their wellbeing.

Quoting Marshall et al., (2003): "the effects of sexual offending (…) can be devastating, and it is the responsibility of society to take action to reduce these problems" (p. 205). Therapists working with sex offenders and delivering sex offender treatment programmes are on the frontline of that action. To be able to effectively treat their patients, they need to maintain positive attitudes, while at the same time managing their personal reactivity to the group of offenders that as a society we do not hold in high regard (Lam et al., 2010; Willis & Levenson, 2010). This is not an easy task, but the more is known about their experiences and factors influencing the effectiveness of delivered treatment, the more can be done to support therapists in their role, effectively treat sex offenders and reduce reoffending.

### *Limitations*

The results of this review are limited by the fact that only studies written in English were included. Another weakness is the application of inclusion and exclusion criteria aimed at achieving the homogeneity of revived papers, which might have resulted in excluding valuable and informative studies.

Additionally, since only the studies published or made available before the cut-off date were included, there is a possibility that further studies, answering the research question of this review, have been published since.

This systematic review only considered studies that were available in English and thus may have missed further published research. However, it is hoped that this potential bias is small as through the initial search only a few studies were identified that were not in English, with it being unlikely that all of these would meet inclusion criteria. In addition, a number of studies (4) were published this year, possibly indicating an increase of research in this area. Due to the arbitrary cut-off of the search date it is possible that further studies will have been published since then. Whilst this could be a limitation of

this study, it is hoped that this timely review will guide future research and reduce the issues highlighted above.

Lastly, the role of the researcher needs to be also considered. I am a trainee Clinical Psychologist, currently working with sex offenders in clinical practice, and therefore my own beliefs and worldview might have impacted on the selection and the interpretation of results of the reviewed studies. My experience of delivering therapy to sex offenders and establishing a therapeutic alliance with them might have affected my perspective on the impact of attitudes on therapeutic alliance, and the impact of the above on the outcomes of therapy.

### *Conclusion*

This review sought to examine therapists' attitudes towards sex offenders, and the impact of attitudes on therapeutic alliance with their patients. The studies included in the review varied in terms of research aim and methodological quality. While the reviewed literature was difficult to synthesise, it provided some interesting and valuable findings. Through the experience of working with sex offenders therapists' attitudes appeared to become more positive, however the therapists were found to experience a mixture of negative and positive feelings towards their patients. Therapists were also reported to use a range of strategies to enhance positive attitudes and the forming of therapeutic alliance.

The findings from this review have implications for theory, as well as clinical practice, however it is clear that more research is needed.

**Declaration of interest**

The author reports no conflict of interest.

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### Contents list

- Health and safety

Submitting your paper

Data Sharing Policy

Publication charges
Copyright options
Complying with funding agencies
Open Access
My Authored Works

Article reprints

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## Appendix 2: The Clinical Appraisal Skills Programme (CASP) Qualitative Research Checklist


### 10 questions to help you make sense of qualitative research

**How to use this appraisal tool**

Three broad issues need to be considered when appraising a qualitative study:

Are the results of the study valid? (Section A)
What are the results? (Section B)
Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

**Referencing: we recommend using the Harvard style citation, i.e.:**

**Critical Appraisal Skills Programme (2017). CASP (insert name of checklist i.e. Qualitative Research) Checklist. [online] Available at: *URL*. Accessed: *Date Accessed.***

## Screening Questions

**1. Was there a clear statement of the aims of the research?** ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

**2. Is a qualitative methodology appropriate?** ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

## Is it worth continuing?

Detailed questions

**3. Was the research design appropriate to address the aims of the research?** ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If the researcher has justified the research design (E.g. have they discussed how they decided which method to use)?

**4. Was the recruitment strategy appropriate to the aims of the research?** ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

---

**5. Was the data collected in a way that addressed the research issue?** ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the setting for data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
- If methods were modified during the study. If so, has the researcher explained how and why?
- If the form of data is clear (e.g. tape recordings, video material, notes etc)
- If the researcher has discussed saturation of data

---

**6. Has the relationship between researcher and participants been adequately considered?** ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during
  (a) Formulation of the research questions
  (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

**7. Have ethical issues been taken into consideration?** ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

**8. Was the data analysis sufficiently rigorous?** ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

### 9. Is there a clear statement of findings?

❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

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### 10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

## Appendix 3: The Clinical Appraisal Skills Programme (CASP) Case Control Study Checklists


### 11 questions to help you make sense of case control study

**How to use this appraisal tool**

Three broad issues need to be considered when appraising a case control study:

Are the results of the study valid? (Section A)
What are the results? (Section B)
Will the results help locally? (Section C)

The 11 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

**Referencing: we recommend using the Harvard style citation, i.e.:**

**Critical Appraisal Skills Programme (2017). CASP (insert name of checklist i.e. Case Control Study) Checklist. [online] Available at: *URL*. Accessed: *Date Accessed*.**

## (A) Are the results of the study valid?

Screening Questions

**1. Did the study address a clearly focused issue?** ❒ Yes ❒ Can't tell ❒ No

HINT: A question can be focused in terms of

- The population studied
- The risk factors studied
- Whether the study tried to detect a beneficial or harmful effect?

**2. Did the authors use an appropriate method to answer their question?** ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- Is a case control study an appropriate way of Answering the question under the circumstances? (Is the outcome rare or harmful)
- Did it address the study question?

## Is it worth continuing?

Detailed questions

**3. Were the cases recruited in an acceptable way?** ❒ Yes ❒ Can't tell ❒ No

HINT: We are looking for selection bias which might compromise validity of the findings

- Are the cases defined precisely?
- Were the cases representative of a defined population? (geographically and/or temporally?)
- Was there an established reliable system for selecting all the cases
- Are they incident or prevalent?
- Is there something special about the cases?
- Is the time frame of the study relevant to disease/exposure?
- Was there a sufficient number of cases selected?
- Was there a power calculation?

**4. Were the controls selected in an acceptable way?** ❒ Yes ❒ Can't tell ❒ No

HINT: We are looking for selection bias which might compromise The generalisibilty of the findings

- Were the controls representative of defined population (geographically and/or temporally)
- Was there something special about the controls?
- Was the non-response high? Could non-respondents be different in any way?
- Are they matched, population based or randomly selected?
- Was there a sufficient number of controls selected?

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**5. Was the exposure accurately measured to minimise bias?** ❒ Yes ❒ Can't tell ❒ No

HINT: We are looking for measurement, recall or classification bias

- Was the exposure clearly defined and accurately measured?
- Did the authors use subjective or objective measurements?
- Do the measures truly reflect what they are supposed to measure? (Have they been validated?)
- Were the measurement methods similar in the cases and controls?
- Did the study incorporate blinding where feasible?
- Is the temporal relation correct? (Does the exposure of interest precede the outcome?)

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**6. (a) What confounding factors have the authors accounted for?** **List:**

HINT: List the ones you think might be important, that The author missed.

- Genetic
- Environmental
- Socio-economic

**(b) Have the authors taken account of the potential confounding factors in the design and/or in their analysis?** ❒ Yes ❒ Can't tell ❒ No

HINT: Look for

- Restriction in design, and techniques e.g. modelling stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors

## (B) What are the results?

### 7. What are the results of this study?

HINT: Consider

- What are the bottom line results?
- Is the analysis appropriate to the design?
- How strong is the association between exposure and outcome (look at the odds ratio)?
- Are the results adjusted for confounding, and might confounding still explain the association?
- Has adjustment made a big difference to the OR?

### 8. How precise are the results? How precise is the estimate of risk?

HINT: Consider

- Size of the P-value
- Size of the confidence intervals
- Have the authors considered all the important variables?
- How was the effect of subjects refusing to participate evaluated?

**9. Do you believe the results?** ❒ Yes ❒ No

HINT: Consider

- Big effect is hard to ignore!
- Can it be due to chance, bias or confounding?
- Are the design and methods of this study sufficiently flawed to make the results unreliable?
- Consider Bradford Hills criteria (e.g. time sequence, dose-response gradient, strength, biological plausibility)

## (C) Will the results help locally?

**10. Can the results be applied to the local population?** ❒ Yes ❒ Can't tell ❒ No

HINT: Consider whether

- The subjects covered in the study could be sufficiently different from your population to cause concern
- Your local setting is likely to differ much from that of the study
- Can you quantify the local benefits and harms?

**11. Do the results of this study fit with other available evidence?** ❒ Yes ❒ Can't tell ❒ No

HINT: Consider all the available evidence from RCT's, systematic reviews, cohort studies and case-control studies as well for consistency.

Remember

One observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making.
However, for certain questions observational studies provide the only evidence.
Recommendations from observational studies are always stronger when supported by other evidence.

**Journal article 1: Empirical Project**

# "…and it's only when you start working with these people and you remember – actually, they are individuals, they are human beings". The experiences and attitudes of support workers who work with sex offenders with intellectual disabilities

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**Abstract**

The aim of this study was to explore the experiences and attitudes of support workers who work with sex offenders with intellectual disabilities. The sample consisted of four female and seven male participants. Data was collected through semi-structured interviews and analysed in accordance with Braun and Clarke's (2006) six stages of thematic analysis. Support workers were found to be motivated to enter the profession by their values and beliefs, such as that everyone deserves help. Participants reported having positive attitudes towards sex offenders, perceiving them as human beings, as well as some negative attitudes like mistrust. Some negative impact of the occupation was described by respondents, although they used coping strategies to manage some of these. Attitudes towards sex offenders with intellectual disabilities were found to be quite diverse. Some gender-related differences were outlined in relation to the perception of safety and courtesy stigma.

## Introduction

### *Public attitudes towards sex offenders*

Sex offending can be defined as "the inducement or coercion of adults and children into sexual activities to which they have not given true consent, and sexual violence as physical and emotional violation to attain sexual gratification from a person unwilling or unable to consent to the activity" (Pakes & Winstone, 2007; p. 75). Public perception of sex offenders is known to be more negative than of general offenders (Lam et al., 2010; Willis & Levenson, 2010). Studies suggest that the media portrayal of sex offenders tends to be negative (Kjelsberg & Loos, 2008, Radley, 2001), and that large proportion of the public seems to believe that a means of reducing the rate of offending would be introducing more restrictive laws on sex offences, as well as higher prosecution rates (Mancini & Mears, 2010). Indeed, some authors have compared the public attitudes towards sex offenders to a "moral panic" (McCartan, 2004).

The research on public attitudes towards sex offenders appears to be limited (Willis et al., 2010). As shown by the findings of Ferguson and Ireland's (2001), the attitudes of the public may be a complex area. Ferguson and Ireland's study indicated that perception of sex offenders may be related to how familiar a person is with that population or offences committed by them. The authors reported that victims of sexual abuse, or people who know closely someone who experienced sexual abuse, hold more positive attitudes towards sex offenders than those, who had no such experiences. In terms of offering an explanation for that relationship, the authors suggested that people with the experience of victimisation may have a better understanding of the complexity of sex offending, and therefore be less likely to perceive sex offenders in a stereotypically negative way (Ferguson & Ireland, 2001).

A survey conducted by Brown (1999) provided insight into public attitudes towards rehabilitation of sex offenders, who had completed their prison sentences, and were about

to be reintegrated back into society. The results of a survey completed by the members of the public indicated that while the participants had positive attitudes towards the treatment of sex offenders, they were not supportive of the idea of the treatment taking place in their own community. The psychological treatment of sex offenders, while necessary, was also viewed by the respondents as unlikely to have any long-lasting effects. Only about a third of the participants perceived sex offenders as able to learn to control their behaviour, and therefore to avoid reoffending. Finally, the majority of participants stated that, given a choice, they would refuse to offer accommodation or employment to a person known to be a sex offender (Brown, 1999). More recent research suggests that these attitudes became even harsher, and that the public became even less supportive of rehabilitation of sex offenders in community (Brown et al, 2008). While Oliver and Barlow (2010) suggest that public support of treatment of sex offenders may be increasing, they also report that the vast majority of their respondents postulated for harsher punishment of sex offenders.

***Professionals' and paraprofessionals' attitudes towards sex offenders***

For sexual offending interventions to be effective, the areas that need to be addressed are not just deviant sexual interests, but also other factors related to offending behaviour: antisocial attitudes and lack of supportive relationships and positive social influences, as well as mental distress and low self-esteem (Yates, 2013). While these aspects can be addressed in the therapy room, the contributions that other staff involved in sex offenders' treatment and management may make on the process of rehabilitation cannot be overlooked, and it could be hypothesised that positive attitudes of such staff could aid the rehabilitation of sex offenders.

An example of such would be the Circles of Support and Accountability, a project employing community volunteers, who help high-risk sex offenders that have just finished serving their prison sentences, to reintegrate back into the society. While the volunteers aim to confront the offending behaviour and prevent reoffending, they also offer sex offenders day-to-day support and companionship (with the motto of the

organisation being: “no-one is disposable”), and help them to develop healthier, pro-social lifestyle (Hannem & Petrunik, 2007). The intervention was shown to be effective, with reduction is sexual recidivism being as high as 83% (Wilson et al, 2009).

It appears, from the limited literature available, that personnel working with sex offenders held more positive attitudes towards them, than members of general public (Ferguson & Ireland, 2006; Johnson et al, 2007, Nelson et al., 2002), and that forensic staff working more closely with sex offenders (probation officers and psychologists) held more positive views of them than staff whose interactions with them were limited (police and prison offices) (Hogue, 1993).

Some studies, using qualitative methodology, provide more detailed information about the attitudes of staff working in this area. Lea et al. (1999) used qualitative approach to gain insight into the attitudes of the police, prison and probation officers, and assistant psychologists, working with sex offenders. The findings indicate that the attitudes of staff appear to be related to the level of training they received (more positive attitudes amongst staff receiving most training) and that the majority of staff experiences a mixture of positive and negative attitudes towards sex offenders. Staff attitudes also appeared to be determined to a degree by the type of offence committed by the individual: rapists were viewed as aggressive, psychopathic and predatory, driven by the need of domination and control, while paedophiles were perceived as more introvert, but also deviant, and driven by the need of affection and company. The research findings also highlighted poor organisational support and insufficient level of training, as well as high levels of staff burnout and staff turnover (Lea et al., 1999).

### *Attitudes towards sex offenders with intellectual disabilities*

The existing research on attitudes towards sex offenders has focused largely on the general population of sex offenders, and little is known about attitudes towards sex offenders with intellectual disabilities (Steans & Duff, 2018; Carson et al, 2010). Researchers agree that individuals with intellectual disabilities, who commit sexual offences, prove a particular challenge to the legal and community care system (McKenzie et al., 2001; Lindsay, 2009, Steans & Duff, 2018). Historically, sex offences committed by people with intellectual disabilities often remained unreported, mainly due to the differences in perception of what constitutes as sexual offence in a person with intellectual disability, lack of relevant policies, and insufficient support from criminal justice system (McKenzie et al., 2001; Lyall et al, 1995). Authors have found it difficult to reach a consensus on the proportion of people in the criminal justice system with an intellectual disability (Lindsay, 2002). However, in a study conducted within Community Learning Disability Forensic Services, the greatest proportion of referrals relates to sex offending (Lindsay et al. 2004). It appears that their number in the community is high enough to cause concern – in addition to consuming significant portion of public resources, the existing research on sex offenders with intellectual disabilities is very scarce (Carson et al, 2010).

While in the past any form of sexual expression in people with intellectual disabilities was perceived as unacceptable and inappropriate (Craft 1987; Mitchell, 1992), a more recent study indicated that these attitudes became more liberal to a degree (sexual intercourse or homosexual relationships still viewed as unacceptable in people with intellectual disabilities) (Yool, 2003), alongside acknowledging that sexual repression is likely to have a detrimental effect on an individual with intellectual disability, and may result in increase in displaying sexually inappropriate behaviour (Harris, 2004).

### *Support workers, who work with sex offenders with intellectual disabilities*

Very little is known also about day-to-day experiences of staff supporting sex offenders with intellectual disabilities, and about their attitudes towards the service users. A quantitative study by McKenzie et al. (2001), looking at attitudes of social care and nursing staff, offers some insight into that matter. The findings indicate that while 75% of social care staff was reported to have positive attitudes towards sex offenders with intellectual disabilities, only 51% of nurses felt the same about their patients. Both groups were also reported to experience a range of negative attitudes towards their patients, however, while nurses tended to hold a negative attitude to an individual as a whole, social care staff were more likely to feel negatively about the challenging and offending behaviour of a patient, rather than expressing a negative attitude to them as a person. The study also revealed that nurses and social care staff lacked relevant training and felt that they did not have sufficient skills or confidence in working with sex offenders with intellectual disabilities (McKenzie et al., 2001).

A recent quantitative study conducted by Steans and Duff (2018) examined the attitudes of forensic staff (the greatest proportion of whom were support workers) working with sex offenders with intellectual disabilities. As well as comparing staff attitudes with general public, the study focused on different perceptions of sex offenders with normal IQ and intellectual disability in terms of their liability for their offence, and level of risk they may present with. The research findings indicated that forensic staff held more positive attitudes towards sex offenders with intellectual disabilities than the comparison group. Additionally, the offenders with intellectual disabilities were perceived by staff as less to blame for their offence. In terms of risk, they were considered to be a higher risk level than general population of sex offenders due to higher likelihood of physically assaulting staff. It was also reported that forensic staff tended to hold more positive attitudes towards sex offenders with intellectual disabilities who presented with lower levels of risk to staff, and lower risk of reoffending (Steans & Duff, 2018).

The role of support workers is in fact a multitude of roles: it combines supporting an individual to reintegrate back into the community with the risk management and reoffending prevention responsibilities. It focuses on promoting independence and teaching living skills, while adhering to release conditions and restrictions. It is a unique role, and it comes with unique challenges – support workers often work with sex offenders with intellectual disabilities on their own or accompany them in a community on a 1:1 basis. Support workers contribute to creating a therapeutic environment in which rehabilitation of sex offenders in community can take place. While their input can maximize the effectiveness of psychological or pharmaceutical treatment, it is also an intervention in itself.

***Rationale for the research.***

At present, the literature on attitudes towards sex offenders with intellectual disabilities appears to be very limited. While currently available literature provides insight into attitudes of certain staff groups working with sex offenders, the area of attitudes of support workers appears to be less explored.

Taking that into consideration, it seemed that a quantitative methodology might not be the best choice of design to gain insight into and gather information about the attitudes of support workers towards sex offenders. With the objective of quantitative research being to test hypotheses (Creswell, 2013) some assumptions would have to be made ad hoc. It appears that since so little is known about support workers' day-to-day experiences of working with sex offenders, a qualitative study offered a methodological approach better suited to exploring their attitudes. Additionally, the area of their work could be a difficult field to approach from a quantitative standpoint due to the individual differences between support workers, as well as between supported by them sex offenders with intellectual disabilities (in terms of presentation and committed offence).

Most importantly, however, a qualitative methodology offers an in-depth understanding of the day-to-day experiences of support staff, their attitudes towards sex offenders with intellectual disabilities and the impact that the job may have on support workers' wellbeing, as well as any other issues that may arise from research.

In addition to offering insight into the experiences and attitudes of support workers, the aim of this study was to derive recommendations for organisational support and training of this staff group, as well as for the future research in the field.

Research objective:

The aim of this study was to gain an in-depth understanding of the experiences of staff working with sex offenders with intellectual disabilities, and the attitudes they hold towards individuals they support.

## Method

### *Ethical considerations*

Ethical approval for the study was gained from the University of Edinburgh School of Health in Social Science Ethics Committee (Appendix 1). Additional advice was requested from the NHS Grampian ethics committee and it was established that no additional ethical approval was required for the project (Appendix 3).

***Participants***

Participants were recruited from care provider services for people with intellectual disabilities and forensic histories in one geographical region of Scotland. Service Managers of appropriate organisations were contacted, and meetings were arranged to present the objective of the study, and to help identify potential interviewees. Service Managers were directly involved in the recruitment process by helping to identify groups of potential interviewees, providing them with information regarding the study and informing them about the opportunity to participate, as well as enabling individuals to make an informed decision about their involvement. Individuals interested in participating were then invited to contact the researcher, and screened against the inclusion and exclusion criteria:

- Aged 18 or over
- Currently working as a support worker with a sex offender with intellectual disability
- Fluent English speaker

If suitable, a meeting was arranged to provide additional information regarding the research, along with the consent forms. Eleven support workers employed by three different organisations were identified as suitable participants, and they consented to participate in the research. All of the participants were provided with an information sheet, prior to consent being taken, describing in detail the aims of the study (Appendix 4).

The interviews were scheduled at the time and venue convenient for the participants and took between 30 to 60 minutes. The individuals involved were informed that they were free to withdraw from the research at any stage and asked not to disclose identifying information about the service users they were supporting, or other support workers involved in their care.

A sample of 11 participants consisted of 7 males and 4 females. Ages of participants ranged from 26 to 61 (average age of 39 years). On average, the participants had 8.4 years of experience as support workers (range 18 months – 25 years) and 4.9 years of experience of supporting a sex offender with intellectual disabilities (range 2 months – 25 years).

Within the sample, all participants had experience of working with an individual with intellectual disability, who had a history of sexual offending, in a support worker capacity. However, the length of employment varied, alongside the degree of experience that each participant had. Nonetheless, given that all participants were employed in a similar role, it was considered that homogeneity in the sample was adequate.

***Data collection***

Thematic analysis was chosen as a method offering flexibility in approaching a broad range of research subjects, as well as being recommended for researchers with limited experience in qualitative research (Braun & Clarke, 2006).

Semi-structured interviews were chosen as a particularly well-suited method of data collection in studies exploring the person's individual experience and attitudes (Braun & Clarke, 2013). The interviews took between half an hour to one hour. They were recorded using a digital recorder, and transcribed verbatim.

The interview questions were guided by the research objectives, previous research conducted in the area, as well as by the participants' responses and information provided (Braun & Clarke, 2013). An interview guide (Appendix 5) gave a structure to questioning, although questioning and the direction of the interview was shaped also by the responses of individual participants. The questions were aimed at exploring relevant areas of support workers' experiences.

***Data analysis***

The data was analysed using Braun and Clarke's (2006) thematic analysis. The data was analysed in accordance with six stages approach. The process was started with the transcription of data into a written format and familiarising myself with the whole content of the collected data. The second stage involved generating initial codes for the thematic analysis, based on the aspects of data identified by the researcher as the most relevant and/or interesting. The third stage involved the process of searching for themes, and sorting of the codes into broader categories. Braun and Clarke's (2006) definition of a theme: "captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (p. 10) was used. The fourth stage was to review identified themes to ensure that they were representative of the category of data that they described, as well as all available data as a whole. At this stage the identified themes were discussed with other researchers (clinical and field thesis supervisors) for the purpose of data triangulation and to enhance the validity of the research (Farmer et al, 2006). The presentation of the themes to interviewees for their appraisal and feedback unfortunately could not be completed due to time constraints. The fifth stage included creating a satisfactory list of themes, further refining, defining and naming them. The final stage was producing the report.

Although the process of the data analysis was conducted according to the provided guidance, it was also influenced by the researcher's potential bias. I am a trainee Clinical Psychologist, currently working with sex offenders with intellectual disabilities, but with past experience of working as a support worker myself. These experiences, as well as my views and beliefs, might have impacted on the process of data collection and interpretation.

## Results

### Theme 1: Working in This Field

The participants spoke about their day-do-day experiences of supporting sex offenders with intellectual disabilities. Four themes emerged from the analysis: *Personal Values in Choosing the Job, Rehabilitation and Reducing Risk*, impact, and *Does Gender Make a Difference in Working with Sex Offenders*.

#### *Subtheme 1: Personal Values in Choosing the Job*

When asked about their experience of working with sex offenders with intellectual disabilities, respondents spoke about the importance of their personal values on choosing their profession and practicing as support workers. The majority of participants stated that they volunteered to work with this population. They spoke about the variety of reasons that motivated them to choose to work with sex offenders with intellectual disabilities:

*Everybody Deserves Help*

Several of the participants stated that their decision to work with sex offenders with intellectual disabilities was linked with a strong belief that everybody deserves help and support, no matter what their personal history or offences committed. Some participants also spoke about how their religious beliefs helped them to apply that attitude to sex offenders:

> *my faith had play a part in this, you know, that everybody (…) deserves a second chance. So everybody deserves compassion, no matter what they've done* (3).

Some participants stated that they'd always had an interest in working with forensic population, since they were passionate about the idea of rehabilitation and helping people in particularly difficult circumstances.

*Personal and Professional Development*

In addition to their willingness to help people, several of the respondents also said that they saw working with sex offenders as an opportunity for personal growth. They saw their role as a challenge that could help them become better people. They described themselves as open-minded and stated that they wanted to learn more about themselves and reflect on their attitudes towards sex offenders.

Some of the participants also wanted to learn about what motivates offending behaviour:

> *I was looking forward to explore what the forensic history of particular person is, what was the reason that the person was housed in this project* (5).

They also wanted to improve their knowledge of forensic mental health and they saw their role as an opportunity for developing a range of new skills.

*Meaningfulness of The Role*

Some of the respondents stated that they perceived their role as more meaningful than other occupations. One of the participants had left his previous job since he believed that as a support worker for sex offenders with intellectual disabilities he was putting his interpersonal skills into a better use and contributing more to society. Others were focusing on the impact that they were making on people's lives, taking pride from being useful and making a difference:

> *I can go home tonight, and I know that today I've made an impact on the world* (2).

Support workers spoke about how much work satisfaction and meaning they were deriving from seeing their clients make even the slightest progress or see them show appreciation for received help. One participant pointed out that while supporting sex offenders with intellectual disabilities may not always bring immediate observable improvements to their wellbeing, it is important to keep trying:

> *If I can make even small changes to his life, probably will be worth, yeah? So why not to try?* (6).

He later spoke about his experience of supporting a client, who had seemed to be making little progress at the time, but later on expressed gratitude for the help he had received and stated that it was of great importance to him. The participant said that experience made him realise how much impact he may make on someone's life and it made his efforts worthwhile.

***Subtheme 2: Rehabilitation and Reducing Risk.***

The participants spoke about rehabilitation and reoffending prevention as being important aspects of their role and they identified different areas in which their support can help sex offenders with intellectual disabilities achieve these goals.

*Living A Better Life*

Several support workers spoke about their perception of offending behaviour as being rooted in deficits in various areas of sex offenders' life, and the offence being a way of meeting unmet needs. Therefore, they perceived their role as helping the offender meet these needs in a socially acceptable way:

> *Some people meet (their) needs in a way which society does not accept, which is obviously dangerous (...). So it's a kind of trying to get people to see that they can*

> *have a good life without that kind of offending behaviour. So that they can have a kind of fulfilling life, including, you know, having intimate friendships and relationships and things like that* (1).

Many of the participants also observed that the majority of their clients had little experience of living what they described as a "normal life", with healthy goals and interests. They spoke about the lack of "independent living skills" in their clients, and the fact that due to the lack of personal resources for many of their clients the offending behaviour was a "go-to" strategy of coping with difficulties. In that context, the role of a support worker was to help sex offenders build a better life, and through that provide an alternative to the offending behaviour:

> *In order for them to no offend again, they need to have some sort of purpose to life, some sort of stability, a settled sort of life. So I've always seen my role (...) to try and actually support somebody... to integrate. (...) By reintegrating, that sort of person wouldn't reoffend, because they would actually see what, a sort of like, normal life looked like* (4).

It is worth mentioning that several of the participants referred to the New to Forensic and Good Lives Model training when speaking about rehabilitating sex offenders. Some of the respondents also pointed out that they saw their role as having nothing to do with the offence, while at the same time reflecting that supporting sex offenders with intellectual disabilities with improving their quality of life does, in fact, contribute to reducing risk of reoffending.

*Building Healthy Relationships*

Two participants observed that in their perception, the offending behaviour of their clients was often related to their limited interpersonal skills, as well as lack of supportive and positive relationships throughout their lives.

One male support worker (2) reflected that many of the sex offenders with intellectual disabilities come from challenged backgrounds, and that they had poor parenting

experience, especially when it comes to the father figure. He identified male sex offenders as frequently having no positive role models in their lives, and therefore not knowing any alternative to the violent, abusive behaviour that they might have observed the males in their environment display. The support worker pointed out that he may be the first male in his clients' lives who acts differently, and that by being a positive role model he can help sex offenders to change.

Interestingly, a female participant spoke about lack of healthy relationships with women in sex offenders' lives, and how that can impact on their offending behaviour:

> *Because somebody might be a risk to women, but at the same time they are out in the community and they can meet women anywhere. So is it not best to try and (...) support somebody on how to actually talk to women properly, how to treat women, how to (...) practice social skills (...) before actually going out and trying to have friendships with women and try and... well to get any sort of relationship with women. I always think it's best to like use skills that women have to support people* (4).

*Learning Skills*

Several of the participants stated that they perceive helping their clients to achieve independent living skills as an important aspect of their roles. One respondent, however, stated that he sees the educational aspect of his role as extending to teaching skills aimed at directly addressing the offending behaviour in sex offenders with intellectual disabilities. He spoke about his experience of supporting an individual who seemed to have little ability to stop himself from reoffending:

> *I was like this… bodyguard, just next to him… just to stop (the offending) happening. And if I wasn't there, then there was no inhibitors there. So then I started going on courses and learning how to work and how to upscale him (…) so that when they bodies are saying they want something, their minds have got to kick in and say, wait a minute, does that person desire that?* (7).

***Subtheme 3: Impact***

The respondents spoke about how working with sex offenders with intellectual disabilities impacts on their wellbeing, as well as perception of risk. Support workers also offered some insight into the coping strategies that they use to be able to cope with difficult aspects of their job.

*Vicarious Trauma*

Some of the participants spoke about being exposed to traumatising content (verbal or written), that had implications for their wellbeing.

One participant was in a situation where a service user started talking about his offence, speaking about his victim in a derogatory way:

> *I mean, normally you can go into the office and, you know, debrief, talk, put my notes down… (…) I could just process that in my head… (…) that's me, I've shut work out. For about 3 days I couldn't do that. I really struggled with it* (2).

For one respondent, the traumatic response was related to finding out about the details of the offence committed by a service user, while another support worker felt badly affected by reading about the childhood abuse and neglect of a sex offender with intellectual disability, that he was supporting:

> *I didn't really believe, I was really very surprised that something like that happened, you know… and… it was hard, you know frankly speaking. It was like… I was really shaking, you know. Because… nobody probably want to be in such situation* (6).

*Impact on Perception of Safety*

Some of the participants addressed the issue of how their perception of personal safety changed through their experience of working with sex offenders.

*Increased sense of safety:* the majority of participants stated that through work experience and education their perception of safety improved. One respondent stated that becoming more familiar with the system around monitoring sex offenders made her feel more secure:

> *if you know that certain people are out in the community, they are quite high risk, you know being involved that everything's been put in place to ensure that people are safe? (...) It does make me feel more aware of other people's roles, particularly the police and how much work they've put into monitoring somebody. (...) it does make you feel quite safe* (4).

*Potential loss of safety:* one participant, although feeling that his sense of safety improved, pointed out that he is still mindful of the fact that his occupation comes with potential risk to him and his family:

> *So, now, I'm not working with people who is in prison, I'm working with people who is getting rehabilitated back into the community. Now we've stopped working with them, they still know me* (7).

Another described being more hypervigilant because of his experience of working with offenders:

> *well maybe I would be more aware of people, again because everybody can have an offence* (8).

*Coping Strategies*

When discussing the impact of working with sex offenders with intellectual disabilities, a number of participants referred to the coping strategies that they use in their daily practice to deal with difficult feelings.

The majority of participants felt that their organisation provided them with sufficient support and opportunities to address any difficulties that may occur when working with sex offenders. They also stated that they valued the provided formal supervision. Two participants had a different experience, and they felt that their organisation did not focus enough on the wellbeing of their staff and that supervision was not provided frequently enough.

The respondents reported that they appreciated the support of their colleagues, and feel that talking to more experienced staff is an important coping strategy that they implement on frequent basis:

> *I always find that if I have a difficult shift or anything like that, it's always good to rewind the situation and talk about it with my colleagues, because more often than not they've been through that situation themselves…* (8).

In addition to benefitting from the support within their organisations, the support workers spoke about a range of self-care strategies that they use outside of work, including talking to friends and family, or using their free time for relaxing, enjoyable activities. Three participants also spoke about the importance of keeping work and personal life separate:

> *I think I realised that you have to leave that behind… you always need to compartmentalise that… that's for work… and I'm much better to do all the things, you know, switch off your phone…* (1).

Some participants stated that their values and personality traits help them cope with difficult aspects of their job:

> *So I think with those people you need to (…) yourself become positive person, so I think you can encourage positivity more. The best way, I think, you know?*

*Change yourself, and once you are yourself positive, you can pass on to your clients* (10).

### *Subtheme 4: Does Gender Make A Difference in Working with Sex Offenders?*

The issues discussed in this subtheme: perception of personal risk, when working with sex offenders, and courtesy stigma, were discussed across the majority of the interviews with both male and female participants. It appears, however, that some interesting differences can be outlined in the perception and experiences of support workers, when divided by gender.

#### *Impact of Gender on Perception of Personal Risk When Working with Sex Offenders*

Some male participants stated that it could be less risky for them to work with sex offenders, than it would be for a female:

> *I think man sometimes – is not like that, but these clients sometimes can get a bit more scared for man? that's the only thing that maybe I can see. Sometimes... girls, yeah... some, not all, can be a bit more shocked or whatever, they smaller, sometimes man a bit stronger than a woman* (10).

One male participant pointed out that female support workers could also feel more vulnerable when working with sex offenders with intellectual disabilities:

> *Say, one of female colleagues, say maybe one of the service users say something (…) Like, you look nice today or something. They may panic, they may think – oh, god, what's going on here. I mean, it may be quite an innocent thing, but because you work in this field, the context, you begin to think… I am not comfortable with that* (10).

Interestingly, only one female participant (9) reported feeling concerned over her own safety, but only when she just started working with that population, and which she

attributed to lack of experience in working with the population. The other female participants, taking part in this research, stated that they never felt concerned about their personal risk when working with sex offenders. One female respondent (4), however, spoke about her experience of male work colleagues worrying about her safety. When she had been first employed to work with sex offenders, she was the only woman in the team, and most of her colleagues seemed to believe that due to risk issues, only males should work with sex offenders.

On a similar note, a male participant spoke about his experience of being seen as better suited to work with high-risk cases due to his gender and physique:

> *I think because of my size, because I'm a big framed guy, they started putting me more… the stereotype… they started putting me more with people with challenging behaviour* (7).

*Courtesy Stigma*

Nine participants discussed people's reaction to their choice of work field. Three participants had positive experiences, even though concerns would be expressed over their safety. Interestingly, all respondents who experienced positive reactions were female.

The remaining participants, all of them male, experienced quite different reactions. One respondent pointed out that the reaction that a support worker receives, when speaking about working with sex offenders, is determined by gender:

> *you know… when you, for example at a party, and somebody says – what do you do for a living? I rehabilitate sex offenders. Now if a woman says it, they'll get a reaction. Now if I guy says it, he'll get a totally different reaction* (7).

Several respondents gave other negative examples. Two participants stated that speaking about their occupation often warrants an awkward silence, or withdrawal of conversation

altogether. One participant spoke about the impact his occupation had on meeting new people and dating:

> *when you say sex offenders, there's terms rape, underaged, exposure, whatever, and all that I would say was yes or no, and I could just see her face change. And it was kind of like… with all that was being said, was like: how could you work with such people? (…) I knew that one date was all I get* (2).

That same participant stated that due to negative experiences and prejudice towards sex offenders, he does not really talk about his job to people other than trusted friends and family. One more respondent shared similar attitude (8).

Two participants, in addition to negative responses, experienced what might be perceived as a personal attack, with one support worker (5) being told that there must be "something wrong with him" if he enjoys working with sex offenders, and another feeling that because of his association with sex offenders, people may presume that he supports offending behaviour:

> *I stop becoming a worker, they forget the worker bit… all they hear is sex offender, and I've become that person. uhm… that was disgust, that was… and then I got slapped once from a woman* (7).

In addition to becoming a scapegoat for vengeance against sex offenders, that same participant's fitness to be a father was questioned. The negative public attitudes towards sex offenders also had an impact on his family life and relationship with his children:

> *How can somebody like me raise kids? Coz they see me as a sex offender now, they don't see me as a worker. How can I raise kids? (…) My children didn't know what I did. Say imagine my kids, they going up to school and say… so what your dad's work is? (…) I couldn't sit and have a conversation with my kids, of the… this is what dad does for a living* (7).

Despite these negative experiences, some support workers stated that they perceived the impact of negative reactions to their occupation as "not as bad", and that it did not discourage them from continuing to work with sex offenders.

**Theme 2: Attitudes of Support Workers**

The respondents discussed their attitudes towards sex offenders and sex offenders with intellectual disabilities. Four subthemes emerged from the analysis: *Attitudes Towards Sex Offenders with Intellectual Disabilities Are Not That Different but Not the Same, Sex Offenders Are Human Beings, The Offence Impacts on The Offender, And Sex Offenders Are Complex.*

***Subtheme 1: Sex Offenders with Intellectual Disabilities Are Not That Different but Not the Same***

Most of the participants, who took part in this research, had experience of working with both general population of sex offenders, as well as with sex offenders with intellectual disabilities. The majority of respondents stated their attitudes towards sex offenders with intellectual disabilities are not any different from their attitudes towards the general population of sex offenders. Some participants observed that since their clients are usually on the mild spectrum, their intellectual disability is not particularly noticeable. Others said that in their experience, many of the sex offenders in general population present with low IQ and may be quite likely to have an undiagnosed intellectual disability. One participant pointed out that sex offenders often present with a comorbidity of some sort, and intellectual disability is simply another issue that they may be affected by:

> *everybody I've worked with (...) they have a diagnosis of some mental health issues, so schizophrenia, Asperger's or the autism spectrum etc. (...) people with intellectual disabilities... I mean, the ones that I've worked with, (...) in my opinion, it doesn't change, my attitude doesn't change.* (2)

A number of participants pointed out that the service user's intellectual disability would not impact on their attitudes, but rather on the practical aspects of support, like communication with the person or a range of offered activities, accessible to them.

While the majority of support workers stated that a diagnosis of intellectual disability would not impact on their attitudes towards sex offenders in their day-to-day practice, it seems that there was less consensus amongst the participants when it comes to the legal aspect of sex offending.

Some of the support workers stated that if an offender has an intellectual disability, that can be a factor contributing to the offending behaviour, since they may have less ability to control their sexual impulses:

> *with someone who has learning needs, who's working on… (…) maybe more on instincts than thoughts. I have more maybe an understanding of where they going, why they are… if possibly not doing it out of badness, but just a feeling, if that's right.* (7).

Another participant (8) pointed out that a large proportion of sexual offenders grew up in institutions, and that they do not have the sexual maturity that other people have. Others said that due to their limited comprehension, sex offenders with intellectual disability may not understand fully the implications of their offence and the impact of it on the victim, or even that what they did was wrong.

Other participants, however, argued that a diagnosis of intellectual disability makes no difference to the victim of sexual offending, and that the impact on them is just as great. Therefore, sex offence is still a sex offence, and the person should be held accountable for it, regardless of what could be perceived as mitigating circumstances.

One participant (7) spoke about his experience of working with a general population of people with intellectual disabilities in the past, and the different perception of what constituted as sex offence, depending on the person's level of intellectual functioning:

> *I'd be sexual offending if he didn't have down syndrome. But because he's got down syndrome it's being seen as sexually inappropriate behaviour* (7).

The participant pointed out that not reporting offences committed by people with intellectual disabilities means that the person may never realise that what they're doing is wrong. As a result, the behaviour can escalate to the level when they may commit a far more serious offence and face severe consequences.

### *Subtheme 2: Sex Offenders Are Human Beings*

While the majority of the participants stated that they'd always had positive attitudes towards sex offenders, others said that working with that population changed their attitudes in a positive direction. All of the participants however spoke about how their work experiences impacted on the way that they perceive sex offenders.

Several of the respondents spoke about how meeting a sex offender for the first time compared to their expectations. Some participants reflected on how the media portrayal of sex offenders shaped their perspective on sex offenders, and how surprised they were to find that their clients were just people, and not that different to any of us:

> *we're all consumed by media, you read the papers... Before I started working in this field, you see it like... monster did this, and this person's been like... and it's only when you start working with these people and you remember – actually, they are individuals, they are human beings* (2).

Some support workers stated that seeing sex offenders as human beings was not something that they were expecting to experience, until they started working in the field. The participants spoke about the peculiar feeling of finding out that they and their clients had something in common, for example that they supported the same football team. Others spoke about their surprise at finding out that sex offenders had other interests in life than just sex, and that just like the rest of us, they may enjoy socialising or going to the gym.

Several of the participants pointed out that sex offenders do not seem any different to the rest of us, and that you cannot tell whether someone is a sex offender just by looking at them. Others described sex offenders as "normal" or "nice" and stated that they are quite likeable people.

One of the participants said that while most people perceive sex offences as the most atrocious crimes, not many of them realise that the spectrum of sex offences is very broad, and that in some cases we can be closer to becoming sex offenders than we think. He also pointed out that sex offenders in our society represent the aspect of human behaviour that most of us do not want to acknowledge that we are capable of:

> *It can be anyone. Given the right circumstances, almost certain circumstances, you know, it could be you, you know. It's not someone different, this person is not some kind of devil or inhumane – this person is a human being* (1).

Another participant said that people are not doing themselves any favour by trying to pretend that the problem of sex offending is not something that may concern themselves or people in their close environment:

> *And who's telling you that maybe tomorrow it's not your son? You have a son, now is a kid, is very cute in there. Who's telling you he don't have an issue like that in the future?* (10).

*Separating Offence from The Person*

The majority of participants stated that they perceive their clients as more than just their crime. One respondent said that while in the past he had used the term "sex offenders" now he makes a point of referring to them as "people who committed sexual offences" (2).

One participant spoke about the value of the advice that she had been given on her first day by a more experienced support worker:

> *he did say something quite poignant (...) – whatever you are reading here, you have to just leave your prejudice at the door. (...) That's something that I really found, like, over the years that somebody might look very... he might look horrible awful on paper, but actually meeting them face to face is a completely different experience* (4).

One of the respondents (1) said that, whenever possible, he always tries to meet the client first, before reading their file, to make sure that he sees the person for who they really are, and not for the crime that they committed. Another stated that when it comes to working with sex offenders, he has a "the past is in the past" rule – his focus is on supporting the client now, and on what can be achieved in future.

Several of the participants stated that they make a clear distinction between their area of work and any legal aspects of their clients' past history of offending and stated that it's not their role to judge the person, but to support them.

One participant pointed out that the fact that someone committed an offence, does not mean that they themselves accept their offending behaviour any more than anyone else around them:

> *Just because the person is forensic doesn't mean it's not a human being. And it's not that the person doesn't struggle with it? (...) I can tell that the person is struggling with the fact that the person likes vulnerable people* (5).

### ***Subtheme 3: Sex Offenders Are Complex***

The participants spoke about the complexity of working with sex offenders with intellectual disabilities, as well as of the challenges of working with that population. This subtheme also offered insight into some negative attitudes held by support workers in relation to their clients.

*The Bigger Picture*

The majority of participants spoke about the fact that most people do not understand how complex sex offending is. They said that the public would prefer to see sex offending as an act of badness and ignore the "bigger picture" that may put the offender in a different light.

Several of the respondents stated that the majority of their clients had very difficult lives, which was meant to affect them to some degree:

> *Most of these people have had fairly poor upbringings and some of them have been in institutions for their whole lives. (…) I think, probably very high percentage of our service users have themselves been victims of various types of offences (…) so… we are working with the victims, just not in that kind of way* (8).

Other participants focused on sex offending being a sign of distress. They stated that at the time of offending their clients were "in a bad place" (2), others stated that offending rarely happens out of context, and is related to multiple factors, that can sometimes be seen only after the offence occurred. The respondents said that while that does not justify what they did, it helps them understand how the person might've ended up committing the offence.

*Mistrust*

The participants discussed the impact on the offence on their engagement with their clients and their attitudes towards them. They also addressed some of the behaviours of sex offenders with intellectual disabilities, which triggered off negative emotional response in them.

*Two sides to sex offender.* Some support workers experienced difficulties coming to terms with what they described as "two sides" to the people that they were supporting:

> *I think sometimes there is a bit where you think, that bit about getting to know someone and, almost, like you feel –he's actually quite likeable kind of person. But then that, the other side of things you like – now, wait a minute, he's done all these things and he's actually quite dangerous* (1).

Another participant spoke about a similar experience, where the image of his clients as rehabilitated and ready to re-join the community was clashing with his knowledge of the offences committed by the individuals. While he was able to see a reduction of risk in his clients, he still felt deeply uncomfortable with the idea of sex offenders having access to the same public spaces, as his own children:

> *So if I don't trust them near my children, should I trust them out in the community? (...) Which now I'm speaking about it seems a bit weird, that I'm the guy who is (...) yeah, I think they should be testing, Johnny for example, out in the community and give them trust and that* (7).

*Sex offenders can be manipulative.* Over a half of the respondents spoke about their experience of finding their clients manipulative.

Some participants reflected that while their clients have intellectual disability, that does not mean that they cannot be manipulative:

> *I was told that this gentleman has a very low IQ (...) but just be very careful of him. And from the time I've spent with him I found him to be very intellectual man, very cunning if you like* (8).

Another respondent spoke about a sex offender with intellectual disability, who was choosing to present as less able in an attempt to obtain more support and sympathy:

> *He says for example that he can't read or write. He can certainly read, you know, because he does that, but he maintains that he can't* (1).

Some respondents reflected on the offences committed by their clients. The support workers stated that, looking at the person, they would never think it possible that their clients could be capable of the level of detailed planning and manipulativeness that was required to obtain access to the victim, yet they know that it happened. One respondent (7) also spoke about his client who was attempting to get the staff to agree with him on the content of his distorted thinking in relation to the offence.

### ***Subtheme 4: Public Attitudes***

All of the participants agreed that public attitudes towards sex offenders are predominantly negative:

> *Many people don't have any doubts what to do with these guys, they just say they should be in jail forever* (10).

Support workers talked about the public perceiving helping sex offenders as a "waste of money". They also spoke about negative attitudes towards rehabilitation of sex offenders and their reintegration back to the society. The participants identified several areas of how negative public attitudes may impact on the lives of sex offenders.

#### *Public Attitudes Increase Risk of Reoffending*

Several of the participants spoke about the public ostracism towards sex offenders. Some gave examples of information about sex offenders, living in the local area, appearing on social media to warn others of their presence. One respondent spoke about a sex offender, whose photograph and personal details, alongside the details of his offence, were published in a newspaper:

> *I just thought… part of that guy's whole problem was not being able to get work, and not being able to, you know, set this off his life, and when you put his photo, and his full name and his address in a newspaper, how is he ever going to like, move on. And, you know, get a job and just… which is probably going to be the most likely thing to help him not reoffending* (3).

Several support workers reflected that while the public believes that their punitive attitudes are a solution to the problem, in fact it has an opposite result. They pointed out that for the majority of sex offenders, that only adds up to their struggle, and makes them more likely to reoffend in future. Some of the participants declared that they are trying to challenge these beliefs, and offer a more balanced perspective, using their own experience of working with sex offenders:

> *Sometimes when you give your point of view and, well, maybe people knows the fields you're working, they kind of respect you a bit more, they get maybe a bit more quiet when you say – oh, how about this, have you ever thought about this* (10).

Other participants agreed that public attitudes towards sex offenders need to be changed, and that more needs to be done to promote a more accurate perspective on the rehabilitation of sex offenders.

*Sex Offenders at Risk of Public Backlash*

Several of the respondents observed that while their role involves managing risk that sex offenders may pose to the society, they also need to be mindful of the public retaliating against the sex offender:

> *there is also risk to him, because, often, you know, that thing about society, might see him as a threat, there may be a kind of reaction against that, you know, attack him or something* (1).

One support worker (5) spoke about supporting a sex offender with an intellectual disability, who started to display sexually inappropriate behaviour in public, putting others at risk, but also facing being harmed himself as a result of his actions.

Other participants spoke about the "vigilantes" in the community, who take it upon themselves to serve justice. They also noted that the risk of negative reactions from the public is particularly high in smaller communities, where sex offenders are more likely to be recognised.

## Discussion

Two main themes: *Working in This Field*, and *Attitudes of Support Workers*, emerged from the analysis, providing insight into different aspects of the respondents' experiences, and beliefs held by them about their role and the population that they are working with.

A significant proportion of support workers chose the profession, motivated by their values. Participants stated that they believed that that everyone deserves help, and that to offer such help to people to whom most of the society would not reach out to (Brown et al., 2008) is a meaningful and worthwhile task. These findings link with the wider literature on the influence of personal values on career choice (Lyons et al, 2010; Kristof-Brown et al, 2005). Furthermore, authors have suggested that altruistic work values are particularly important in choosing a profession and organisational sector for employment (Ben-Shem et al, 1991; Choi, 2017). Support workers also showed a high level of awareness of the factors contributing to sex offending, such as social isolation and lack of positive role models, and experienced mental distress (Yates, 2013) and saw their role as helping sex offenders with intellectual disabilities with building healthy and prosocial lifestyles, and as preventing reoffending.

While the majority of the public was reported to hold punitive attitudes towards sex offenders (Oliver & Barlow, 2010), the research respondents argued against severe punishment in favour of rehabilitative approach. The subtheme *Public Attitudes* provided

support workers' perspective on the demonization of sex offenders in contemporary society, and their view of the implications that it may have on the individual's chances of reintegrating into society.

This positive outlook on rehabilitation of sex offenders seemed to occur alongside positive attitudes towards the general population of sex offenders, as well as sex offenders with intellectual disabilities. The subtheme *Sex Offenders Are Human Beings* provided insight into support workers' perception of the group as being just like everyone else. Support workers stated that through their experience of working with sex offenders they were able to see their clients for who they really are, and their offence as separate from the person. While the majority of respondents declared that they always had positive attitudes towards sex offenders, those of the participants who initially held less favourable attitudes, reported that their view of sex offenders improved through the experience of working with that group. That result seems to be linked with Ferguson and Ireland's (2001) findings of attitudes being related to how familiar a person is with a population of sex offenders, professionals' and paraprofessionals' attitudes being more positive than the views of the general public (Ferguson & Ireland, 2006; Johnson et al, 2007, Nelson et al., 2002), and Steans and Duff's (2018) findings of support workers holding more favourable attitudes towards sex offenders than general public. Similar findings have also been reported in regard to stigma related to mental health difficulties. Previous research has found that greater levels of contact with a person suffering from mental health difficulties are associated with relative reduction in prejudice, as well as in social distance (Corrigan et al, 2001; Penn & Martin, 1998).

In addition to positive attitudes, the respondents reported experiencing some negative attitudes towards sex offenders with intellectual disabilities. That appears to be in keeping with McKenzie et al. (2001) and Lea et al. (1999) findings of support workers experiencing a mixture of positive and negative attitudes towards their clients. The negative attitudes, reported by the participants, included mistrust towards sex offenders, and the feeling of being manipulated by them. Additionally, some of the participants reported experiencing impact of working with that population, whether in a form of vicarious trauma or perception of personal safety as less secure.

The support workers however were able to identify a range of coping strategies, that they utilised in their practice to cope with difficult feelings. The majority of participants declared that they perceived organisational support and formal supervision as very valuable for their wellbeing. This is in keeping with other findings about the importance of supervisory support (Ng & Sorensen, 2008) and team learning and emotional support (Buljac et al, 2013) for employees' welfare. The respondents also frequently mentioned support of their colleagues and good work-life balance as important strategies in coping with challenging work-related experiences, in agreement with Viswesvaran et al's (1999) findings of social support having a moderating effect on work-related stress.

When it comes to a general view of sex offenders with intellectual disabilities, the supportive and understanding attitudes of support workers seemed to be also reflected by their inclusive perception of that particular population – a statement made by the majority of the respondents was that in their everyday practice they were not holding different attitudes to their clients on the account of their intellectual disability.

These findings, when interpreted alongside the support workers' motivation for entering the occupation – their willingness to help the clients, regardless of the committed by them sex offences, as well as their perception of sex offenders as human beings, may suggest that the support workers were applying a non-judgemental attitude to every aspect of their clients, whether it was a history of sex offending, or a diagnosis of intellectual disability.

Steans and Duff's (2018) findings in regard to support staff having more positive attitudes towards clients with intellectual disabilities and perceiving them as less to blame for their offence, provided an interesting point of reference. As already discussed, the results of this research suggest that the support workers did not hold more positive attitudes towards sex offenders with intellectual disabilities, than to the general population of sex offenders. Some of the respondents did, however, perceive intellectual disability as a mitigating circumstance. At the same time, other participants observed that culpability for the offence should be perceived with consideration of the impact it had on the victim, and not of the level of intellectual functioning of the offender. Some respondents also pointed out that it is not in the best interest of a sex offender with intellectual disability to walk away free, without facing consequences of his behaviour.

Some interesting findings emerged in relation to the participants' gender. While some male support workers perceived their female colleagues as more vulnerable to risk while working with sex offenders, that observation was not shared by the female participants.

The gender differences were also noticed when it comes to the support workers' experience of talking about their job with people outside of their field of work. While some female respondents stated that they experienced generally positive reactions, male support workers declared that in their experience, people's reactions to their occupation were overwhelmingly negative. One male participant stated that when he tells people about working with sex offenders, the public seems to be perceiving him as a sex offender too, or at least as someone who supports offending behaviour. Some of the participants stated that due to the negative experiences they had encountered, they no longer talk about their job with people other than family and trusted friends. This difference in experiences between female and male support workers could perhaps be related to the fact that the public perception of sex offenders appears to be seeing them as predominantly male (Cortoni et al., 2010). Perhaps female support workers could be at lesser risk of being associated with sex offenders, while for male staff that relationship would become stronger.

Additionally, it is worth considering another possible factor contributing to the perception that some participants held regarding harsher judgements of male support worker by the public around them. Within the care professions, men constitute a minority (around 10%) of the existing workforce (Brown, 2009; Hussein et al, 2010; Purnell, 2007). Hence, this may not be viewed as a typically 'male' role. Negative impact of gender stereotypes in the day-to-day practice of care professionals, including mistrust and questioning of gender identity, are evident in to existing literature (Evans, 2004; Sobiraj et al, 2015; Tollison, 2017). This gender bias, perceived by male staff, may put an additional strain on the considerably vulnerable position of male support workers working with sex offenders.

### *Recommendations for future research*

As already discussed, the area of experiences and attitudes of support workers, who work with intellectually disabled sex offenders, appears to be significantly under-researched. Therefore, it seems that there is a need for a qualitative and quantitative research to be conducted in this field.

A qualitative study, looking into support workers' experiences and attitudes, conducted in a different (or wider) geographical location would provide comparative findings to this study.

Additionally, the findings of this study may indicate some potential areas of interest for future qualitative research. The motivation of support workers to enter the profession as being related to their values appears to be offering an opportunity for further exploration of the factors influencing attitudes towards sex offenders and sex offenders with intellectual disabilities. The notion of gender as impacting on aspect of support workers' experiences in relation to the perception of risk, and talking about their job, seems to be offering potential for more in-depth findings.

A quantitative research, aimed at assessing specific aspects of support workers' attitudes, may reveal findings about this population that a qualitative methodology cannot capture. For example, the majority of the support workers, that this sample consisted of, appeared to be feeling exceptionally well supported by their organisation. A quantitative approach to the impact of organisational support on support workers' attitudes towards sex offenders with intellectual disabilities would provide valuable findings that could guide the management of the organisational side of the community services for this group.

### *Clinical implications*

The findings of this study suggest that while support workers may choose to work in this field, their initial experience of supporting a sex offender with intellectual disability may be challenging for some individuals. Considering that public attitudes towards sex offenders tend to be negative (Lam et al., 2010; Willis & Levenson, 2010) it appears that

less experienced staff may benefit from additional support, creating a safe space to address any difficult feelings that may emerge in the initial stages of work, alongside highlighting training needs for these individuals.

Despite some negative impact of working with sex offenders with intellectual disabilities on support workers' wellbeing, it appears that the participants were able to implement coping strategies to address their difficulties. The strategy that was most frequently mentioned by the participants – using peer support and formal and informal supervision – appear to be providing guidance as to the organisational support that is required by support workers to be able to fulfil their role. Regular and effective supervision, as well as positive workplace culture appear to be effective in minimalizing the negative impact of the role. It can be hypothesised that by ensuring these, better staff retention rates, as well as overall staff wellbeing, can be achieved (Webb et al., 2016).

Lastly, a significant proportion of the participants within the sample discussed the difficulties encountered in rehabilitation of sex offenders with intellectual disabilities, and made recommendations aimed at preventing reoffending. The respondents highlighted their belief in the need for an increase in funding for reintegration of those service users that they work with, as well as for other agencies to become more inclusive when considering accepting sex offenders with intellectual disabilities into their service. Support workers also discussed the impact of negative public attitudes on rehabilitation of sex offenders and the importance of education and interventions aimed at changing that negative view for the benefit of their service users, as well as for society as a whole.

### *Limitations*

The validity of the results of this study could be limited by the recruitment strategy and the representativeness of the sample when compared to the wider population of support workers working with sex offenders with intellectual disabilities. There was a potential of self-selection bias, since the participants were recruited amongst the support workers who volunteered to taking part in the research. The fact that the recruitment was limited to one geographical area of Scotland might have also create a potential for bias – the

analysed attitudes and experiences may be specific to the local population only. Additionally, a significant proportion of the sample was recruited within one organisation, which was described by the participants as offering excellent support to their employees, as well as good training opportunities. That factor might have further impacted on the objectiveness of the collected data.

Additionally, one of the stages of data analysis – presentation of the identified themes to interviewees for their appraisal and feedback – could not be completed due to time constraints. That might have negatively impacted on the validity of the results as well as on the level of accuracy with which the support workers' experiences and attitudes were reflected in this study.

The previously acknowledged role of the researcher in qualitative data also needs to be taken into consideration. In my role as a trainee Clinical Psychologist I work with sex offenders with intellectual disabilities, and I also have an experience of working as a support worker. These personal experiences might have impacted on the process of data collection and analysis. These issues were discussed with my supervisors, both of whom however have background in forensic mental health. Therefore, that strong potential for bias suggests that the researcher's background needs to be acknowledged as a limitation of this research. This background may have influenced the manner in which data was collected within interviews, with lines of questioning and interpretation of answers being linked to the researcher's own experiences of working with sex offenders with intellectual disabilities and attitudes towards that population.

In addition to my clinical experience, the researcher's educational background in Gender Studies might also have influenced both data collection and analysis. As evidence of gender-related differences in support workers' experiences and attitudes emerged during data gathering and analysis, there may have been a particular focus and exploration of this area.

### *Conclusion*

Support workers were found to be motivated to enter the profession by their values and beliefs. As the main focus of their role, they perceived helping sex offenders with intellectual disabilities to live better lives, and to prevent reoffending by their clients. Several of the participants expressed positive attitudes towards rehabilitation of sex offenders and declared negative view of harsh punishment of sex offenders. Participants reported having positive attitudes towards sex offenders, with perception of sex offenders as human beings, as well as some negative attitudes, related to the lack of trust, and to their perception of sex offenders as manipulative. The respondents also reported some negative impact related to working with sex offenders, alongside a range of coping strategies that they utilised in managing these negative experiences and emotions.

Support workers' attitudes towards sex offenders with intellectual disabilities were found to be quite diverse. While the majority of the participants stated that their attitudes towards sex offenders with intellectual disabilities did not vary significantly from their attitudes to the general population of sex offenders, a large proportion of respondents identified a diagnosis of intellectual disability as a mitigating circumstance in relation to the sex offenders' responsibility for committed crime.

Some gender-related differences were outlined in relation to the perception of safety and courtesy stigma.

## Declaration of interest

The author reports no conflict of interest.

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### Contents list

- Health and safety

Submitting your paper

Data Sharing Policy

Publication charges
Copyright options
Complying with funding agencies
Open Access
My Authored Works

Article reprints

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Telephone 0131 651 3969
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Email submitting.ethics@ed.ac.uk

Olga Czosnyka
Trainee Clinical Psychologist
School of Health in Social Science
University of Edinburgh

21 April 2017

Dear Olga,

**Application for Level 2 Approval**

**Reference:** CLIN360
**Project Title:** Attitudes and experiences of male support staff working with sex offenders with intellectual disabilities: A qualitative study
**Academic Supervisor:** Ken MacMahon

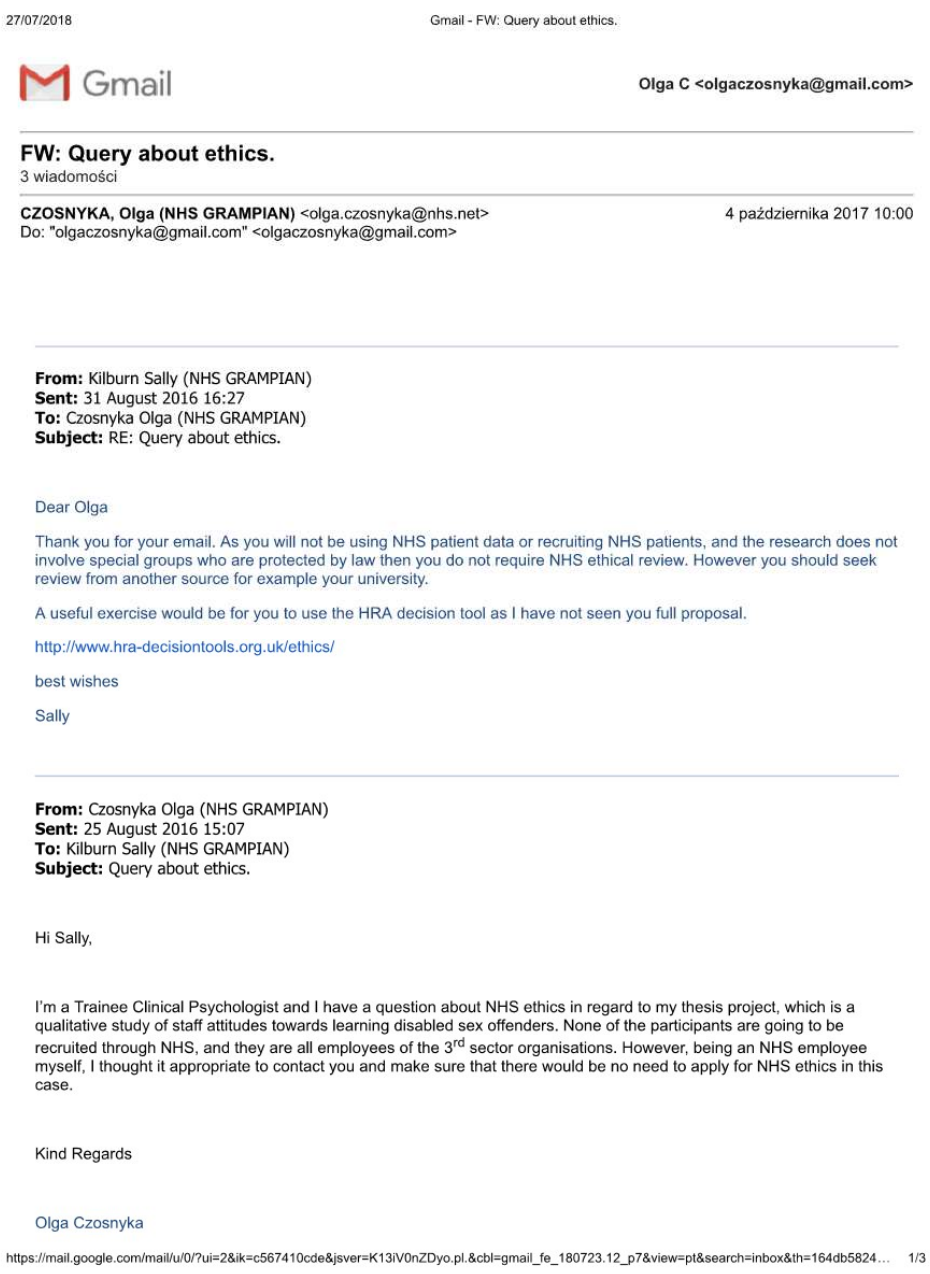
Thank you for submitting the above research project for review by the Department of Clinical and Health Psychology Ethics Research Panel. I can confirm that the submission has been independently reviewed and was approved on the 20th April 2017.

Should there be any change to the research protocol it is important that you alert us to this as this may necessitate further review.

Yours sincerely,

Kirsty Gardner
Administrative Secretary
Clinical Psychology

## Appendix 3: Confirmation email



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3 wiadomości

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Dear Olga

Thank you for your email. As you will not be using NHS patient data or recruiting NHS patients, and the research does not involve special groups who are protected by law then you do not require NHS ethical review. However you should seek review from another source for example your university.

A useful exercise would be for you to use the HRA decision tool as I have not seen you full proposal.

http://www.hra-decisiontools.org.uk/ethics/

best wishes

Sally

**From:** Czosnyka Olga (NHS GRAMPIAN)
**Sent:** 25 August 2016 15:07
**To:** Kilburn Sally (NHS GRAMPIAN)
**Subject:** Query about ethics.

Hi Sally,

I'm a Trainee Clinical Psychologist and I have a question about NHS ethics in regard to my thesis project, which is a qualitative study of staff attitudes towards learning disabled sex offenders. None of the participants are going to be recruited through NHS, and they are all employees of the 3rd sector organisations. However, being an NHS employee myself, I thought it appropriate to contact you and make sure that there would be no need to apply for NHS ethics in this case.

Kind Regards

Olga Czosnyka

https://mail.google.com/mail/u/0/?ui=2&ik=c567410cde&jsver=K13iV0nZDyo.pl.&cbl=gmail_fe_180723.12_p7&view=pt&search=inbox&th=164db5824… 1/3

**Appendix 4: Participant Information Sheet**



Olga Czosnyka

Trainee Clinical Psychologist

NHS Grampian

# Participant Information Sheet

Support staff working with sex offenders with intellectual disabilities: their attitudes towards people that they support and the experience of their work. A qualitative study.

**You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact us if there is anything that is not clear or if you would like more information.**

**What is the purpose of the study?**

This study aims to find out more about the experiences of support staff who work with sex offenders with intellectual disabilities. At present, we know very little about the experiences of those people. We would like to find out more about the experiences of staff and their thoughts and attitudes towards this group. In this study, support workers from Grampian area will be interviewed about their experience of working with intellectually disabled sex offenders, and asked about their attitudes towards the people they support, as well as towards their jobs. The recordings of the interviews will be used to identify similarities and differences in their narratives, in order to describe their experiences. The research findings will be made available to the public, although it will not be possible to identify who has taken part in the research. It is hoped that this study will help us to understand more about the experiences of staff members and how these might shape attitudes. This will help services to offer better support to both staff and offenders with intellectual disabilities.

**Why have I been asked to take part?**

You have been invited to take part in this research because you are currently working as a support worker with a sex offender with intellectual disability.

**Reimbursement for time**

Participation is voluntary and I am afraid that I am not able to offer any payment for your time.

**What will I have to do?**

Participation involves a face-to-face interview that will last between 30 and 60 minutes. The interview will be arranged at a time and place to suit you.

**What will happen if I take part?**

If you are interested in taking part in the study, the researcher will be in contact to arrange a date, time and location to meet with you and give you more information about the study. If you then still with to participate, you will be asked to sign a consent form and then be invited to talk about your experience of supporting a sex offender with intellectual disability, and asked a number of questions around this. The main topics that will be discussed are what your thoughts are about people with intellectual disabilities who are sex offenders, what is it like for you to do this kind of job and how it might affect you professionally and personally.

The interviews will be recorded on a digital audio device and then transcribed with the removal of any information that could be used to identify who you are. Transcriptions will be securely stored on a University of Edinburgh computer. The information collected will be analysed using a method called thematic analysis, which looks at main and important themes appearing during the interviews. Once the analysis is complete, you may choose to have it sent to you to in order to provide you with an opportunity to review these themes and give your opinions about whether they reflect your thoughts about working with this group. This part is not a requirement of participation, and is expected to take around 30 minutes of your time. Your comments on the themes derived will help us to ensure that the responses have been interpreted correctly and to increase our understanding of the perspectives of support workers working in this area.

As a standard procedure with this type of analysis, short anonymised quotations will be used within the thesis; it will not be possible to identify the individual or service provider from the quotation. Even if you do not want any quotations from your transcript included, you can still participate in the study.

**What are the possible benefits of taking part?**

Although there are no direct benefits to the person taking part in the study, it is hoped that it will help us to gain a better understanding of the issues affecting frontline staff, therefore it will have implications for future practice of the services. It is also hoped that exploring staff's existing attitudes and gaining better understanding of their experience would contribute to the existing research on attitudes, which is known to be extremely limited.

**What are the possible disadvantages and risks of taking part?**

There is a risk that confidential information about patients may be divulged during interviews. If this were to happen, care will be taken to ensure that no identifiable information is included in transcripts. The researcher is an NHS employee who therefore understands the importance of confidentiality.

There is a possibility that some participants may report practices that would cause concern around either their fitness to practice, or around the safety of a vulnerable adult.

Although the content of the interviews is covered by the confidentiality clause, meaning that the interviewer cannot reveal your identity and your opinions to anyone else, the interviewer has a legal obligation to report any significant concerns that may be revealed during conversation. Should this occur, the researcher will follow the relevant NHS Health Board and University of Edinburgh protocols to ensure the safety of those who may be at risk. This is likely to include contact with the participant's manager and may also involve contact with Social Work departments in Grampian. All participants will be offered the opportunity to both familiarise themselves with relevant policies, as well as discuss the matter of their concern with the researcher and ask additional questions.

**Do I have to take part?**

Taking part is entirely voluntary and consent can be withdrawn at any time. If at any point during the interview you do not wish to continue, you can decide to stop without giving reason. You have the right to ask that your recording and transcript are destroyed at any time. However, the analytic method used in this study means that it is difficult to remove data when it has been included in the analysis. Therefore, analysis on your data will not start until at least 7 days after the interview. This means **you have up to 7 days after the interview to withdraw all your data**. After this point, the analysis on your transcript may have started. Any requests made after 7 days will be honoured as much as it is practically possible. Any data analysis will stop, and any remaining data will not be analysed. Similarly, all transcripts and audio recordings will be destroyed.

**What if I want to find out more?**

If you want to find out more please do not hesitate to contact the researcher Olga Czosnyka, Trainee Clinical Psychologist at (email for communication with participants to be set up).

You can also contact Dr Ken MacMahon, Senior Lecturer in Clinical Psychology/Academic Supervisor (ken.macmahon@ed.ac.uk or 0131 651 3932).

If you wish to contact someone independent of the study, please contact Dr Angus Macbeth, Lecturer in Clinical Psychology (angus.macbeth@ed.ac.uk or 0131 651 3960).

**Will my taking part in the study be kept confidential?**

It will not be possible to identify any of the individuals who take part in the study from the reports, as all the information will be anonymised.

**What will happen to the results of the study?**

The results of the research project will be presented at a conference for professionals who work with people with intellectual disabilities, as well as made available to the research participants and care providers via newsletter. Additionally, research will be submitted to the University of Edinburgh as a part of the Doctorate in Clinical Psychology programme. It is also planned that it will be written-up for publication in a professional journal.

**Who has approved the study?**

Ethical approval has been granted by the School of Health in Social Science, University of Edinburgh Ethics review board.

**How do I take part?**

If you would like to take part in this research project, please fill in one of the reply slips provided. The researcher will contact you using a method of communication of your choice to arrange a suitable time for an interview and answer all the questions that you may have about the study. Alternatively, you can contact Olga Czosnyka on (*e-mail and phone number* *****).

Thank you very much for taking the time to read this information sheet.

**Appendix 5: Interview schedule**

# Interview schedule

## WHAT DO THEY THINK

To explore the attitudes of staff towards offences committed by people with intellectual disabilities (including level of responsibility).

- What do you think about people with ID who committed sexual offences?
- How do you feel about people with ID who committed sexual offences?
- What did you think/feel about sex offenders with ID before you started working for the service?
- Have your thoughts/feelings about sex offenders with ID changed since you started working for the service?

## WHAT IS IT LIKE

To identify main challenges of working with this particular group and the reality of supporting sex offenders with ID on daily basis.

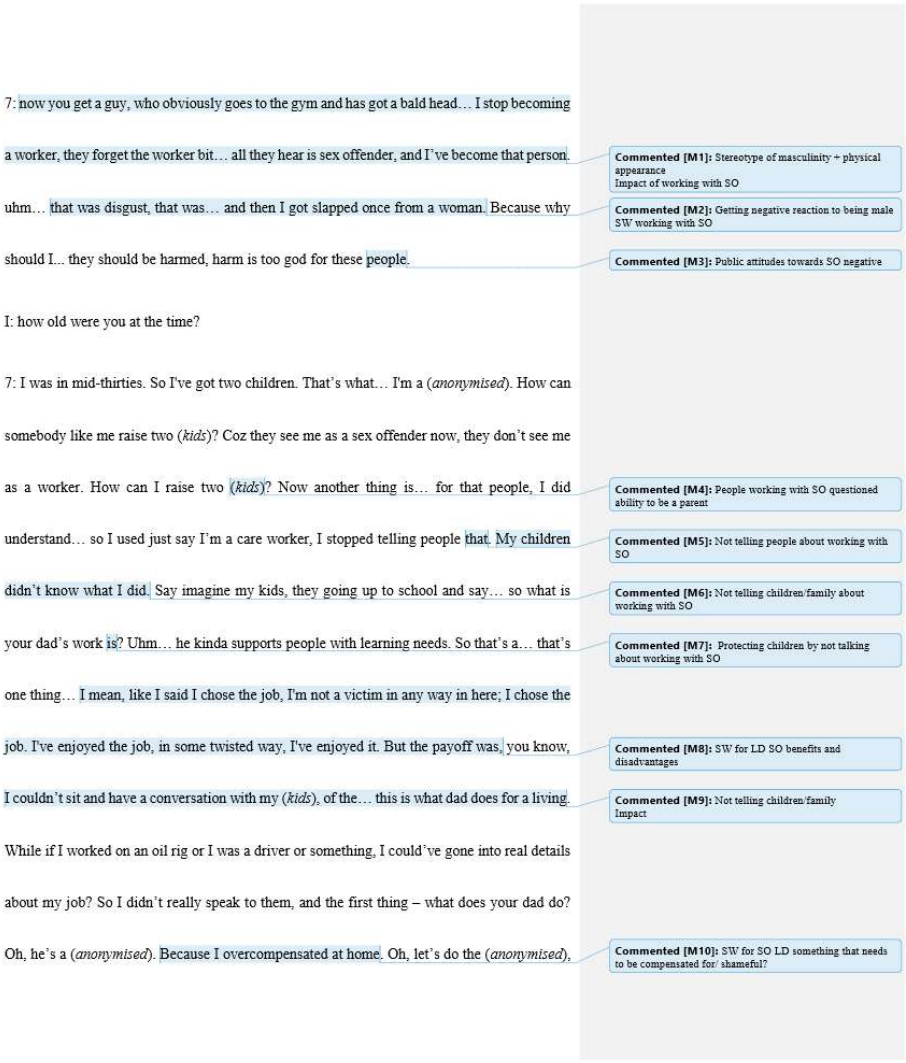
- Tell me about your experience of working with sex offenders with ID.
- What do you find most challenging about your job?

## THE IMPACT

To gain an understanding of the impact (or lack of) of working with sex offenders on the staff's overall wellbeing and areas of life unrelated to work.

- How does this work affect you?
- How are you coping with the demands of the job?
- Do you feel well supported in your role?
- Do you talk to your friends and family about your job?

## Appendix 6: Sample of coding



7: now you get a guy, who obviously goes to the gym and has got a bald head… I stop becoming a worker, they forget the worker bit… all they hear is sex offender, and I've become that person. uhm… that was disgust, that was… and then I got slapped once from a woman. Because why should I... they should be harmed, harm is too god for these people.

I: how old were you at the time?

7: I was in mid-thirties. So I've got two children. That's what… I'm a (*anonymised*). How can somebody like me raise two (*kids*)? Coz they see me as a sex offender now, they don't see me as a worker. How can I raise two (*kids*)? Now another thing is… for that people, I did understand… so I used just say I'm a care worker, I stopped telling people that. My children didn't know what I did. Say imagine my kids, they going up to school and say… so what is your dad's work is? Uhm… he kinda supports people with learning needs. So that's a… that's one thing… I mean, like I said I chose the job, I'm not a victim in any way in here; I chose the job. I've enjoyed the job, in some twisted way, I've enjoyed it. But the payoff was, you know, I couldn't sit and have a conversation with my (*kids*), of the… this is what dad does for a living. While if I worked on an oil rig or I was a driver or something, I could've gone into real details about my job? So I didn't really speak to them, and the first thing – what does your dad do? Oh, he's a (*anonymised*). Because I overcompensated at home. Oh, let's do the (*anonymised*),

**Commented [M1]:** Stereotype of masculinity + physical appearance
Impact of working with SO

**Commented [M2]:** Getting negative reaction to being male SW working with SO

**Commented [M3]:** Public attitudes towards SO negative

**Commented [M4]:** People working with SO questioned ability to be a parent

**Commented [M5]:** Not telling people about working with SO

**Commented [M6]:** Not telling children/family about working with SO

**Commented [M7]:** Protecting children by not talking about working with SO

**Commented [M8]:** SW for LD SO benefits and disadvantages

**Commented [M9]:** Not telling children/family
Impact

**Commented [M10]:** SW for SO LD something that needs to be compensated for/ shameful?

I'm a (*anonymised*) so let's focus on that. So it's not something that you can just have an open conversation.

**Commented [M11]:** Working as SW something that cannot be discussed with children/family

I: do they know now?

7: yeah, one of them works *** (*anonymised*). So it's almost like…. I've tried to hide it from the (*kids*), and one of them turns out and is doing almost similar work, so… (laugh).

**Commented [M12]:** Family members also SW

I: but at the same time it sounds like that must have been incredibly difficult experience for you.

7: yes, you know there's (…) I suppose the way that I've… I've justified it to myself… if I was working in an oil rig, I'd be away from my family for two, three weeks, you know. If I was a night shift, at night I wouldn't see them. So I suppose that was the payoff for me, for the… And also walking up the street was another thing. *** is a small place. I can stand out in a crowd. I'm walking up the road with my two (*kids*), I had a sign that I would give them and they would just walk away from me. We would meet up at a set place where we would always meet up. So, now, I'm not working with people who is in prison, I'm working with people who is getting rehabilitated back into the community. Now we've stopped working with them, they still know me. Now, maybe it's just me being a father, being protective of my children, so if I

**Commented [M13]:** Benefits of being SW – rationale for the job more time with family

**Commented [M14]:** SW risk of being recognised

**Commented [M15]:** SW protecting children from service users

**Commented [M16]:** SO - Threat

**Commented [M17]:** SW people they work with can be a threat to their kids

**Commented [M18]:** SW protecting own children from service users

don't trust them near my children, should I trust them out in the community? So there was the work side of me, and there was the father side of me. And I suppose maybe the ones that I've worked with who don't have a diagnosis if LD, I keep my world very private from them. Normally I work through the exchange model, working with young people I give them a bit of me, exchange that for a bit of them, and get that respect bit going? I never did that when I was working with more mainstream sex offenders.

I: how about SO with LD?

7: I would share things like I've got (*anonymised*), and I need support, you know, I have my (*anonymised*), I would show them things like that, you know, I also need a bit of support. You know, school wasn't so good for me, found out about (*anonymised*), that's a bit of a support there as well. So I would share these things and the fact that I used to be a ***, I'd share that. So you know, we could go to the kitchen and we could do some positive stuff, something for a family member, let's make a cake, something nice, and it was nothing sexualised. It was… it was normal, you know what I mean. So the stuff like, let's do this positive things… so this bits I would share, but when it came to asking about family and things like that… or where I lived and things like that… I always say an address, said it so many times no one could know that I

**Commented [M19]:** SO cannot be fully trusted in community

**Commented [M20]:** Dual role of parent and SW

**Commented [M21]:** SO without LD stricter boundaries

**Commented [M22]:** Boundaries

**Commented [M23]:** Boundaries

**Commented [M24]:** LD SO less strict boundaries

**Commented [M25]:** Finding pleasant activities for SO that are not sex-related

**Commented [M26]:** Modelling positive activities

was lying about it. And I was never married, no family and I just dedicated myself to the job. And that was the story that went in.

Commented [M27]: Boundaries with SO LD. Hiding details of personal life.

I: why?

7: I suppose it was just being overprotective of the children. Which now I'm speaking about it seems a bit weird, that I'm the guy who is working in a… with the police and social services and the psychologists, yeah, I think they should be testing, Johnny for example out in the community and give them trust and that, giving them time on their own and start working there. But yeah, I doesn't kinda stop protecting my own… my own identity, a part of my own identity from it?

Commented [M28]: Protecting own children from service users

Commented [M29]: Family as a priority, limits to trust to SO

Commented [M30]: Separating work and personal identity

I: do you think that because of the job that you were doing at the time that it was harder for you as a father or easier? In terms of being worried about the risk of…

7: I think… yeah, I think it heightens… yeah, I can see… way back at the beginning, I was seeing things that wasn't there, I was looking for, you know, everybody oh, I see you doing this or that, that could be an indicator of that…

Commented [M31]: Hypervigilance re: SO in community